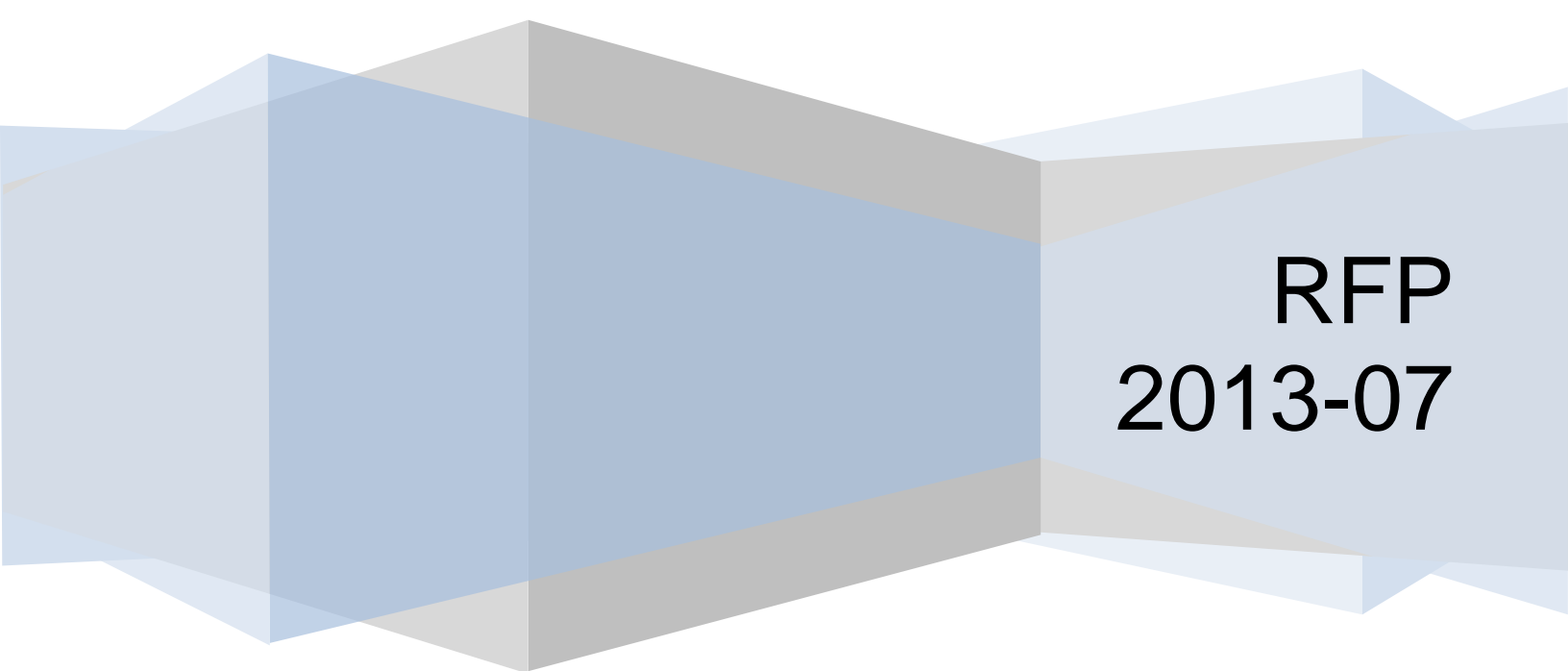


**University Medical Center  
of  
Southern Nevada**

**Request for Proposal  
2013-07**  
Neurosurgery On-Call Services



**RFP  
2013-07**

# University Medical Center Of Southern Nevada

## CONFIRMATION FORM for RECEIPT OF RFP NO. 2013-07 Neurosurgery On-Call Services

If you are interested in this invitation, immediately upon receipt please fax this confirmation form to the fax number provided at the bottom of this page.

Failure to do so means you are not interested in the project and do not want any associated addenda sent to you.

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### VENDOR ACKNOWLEDGES RECEIVING THE FOLLOWING RFP DOCUMENT:

PROJECT NO.      RFP NO. 2013-07

DESCRIPTION:      Neurosurgery On-Call Services

### VENDOR MUST COMPLETE THE FOLLOWING INFORMATION:

Company Name: \_\_\_\_\_

Company Address: \_\_\_\_\_

City / State / Zip: \_\_\_\_\_

Name / Title: \_\_\_\_\_

Area Code/Phone Number: \_\_\_\_\_

Area Code/Fax Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Please indicate the method you used to obtain this RFP Document:

☐ Clark County website    ☐ Received directly from UMC    ☐ Las Vegas Review Journal    ☐ Plan Room

**FAX THIS CONFIRMATION FORM TO: (702) 383-2609**  
**Or EMAIL TO: robert.maher@umcsn.com**  
**TYPE or PRINT CLEARLY**

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA

REQUEST FOR PROPOSAL  
RFP NO. 2013-07  
Neurosurgery On-Call Services

University Medical Center is soliciting proposals for Neurosurgery On-Call Services.

The RFP package is available as follows:

- Pick up - University Medical Center, 800 Rose Street, Suite 409, Las Vegas, Nevada 89106.
- By Electronic Mail or Mail – Please email a request to Contracts Management at [robert.maher@umcsn.com](mailto:robert.maher@umcsn.com) specifying project number and description. Be sure to include company address, phone and fax numbers, email address or call (702) 207-8846.
- Internet – Visit the Clark County website at <http://www.clarkcountynv.gov/purchasing>. Click on “Current Opportunities”, scroll to bottom for UMC’s Opportunities and locate appropriate document in the list of current solicitations.

Proposals will be accepted at the University Medical Center address specified above on, or before, **February 28, 2013** at 2:00:00 p.m., based on the time clock at the UMC Materials Management office. Proposals are time-stamped upon receipt.

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PUBLISHED:  
Las Vegas Review Journal  
February 10, 2013

GENERAL CONDITIONS  
RFP NO. 2013-07  
Neurosurgery On-Call Services

1. TERMS

The term "OWNER," as used throughout this document will mean University Medical Center of Southern Nevada. The term "BCC" as used throughout this document will mean the Board of Hospital Trustees which is the Governing Body of OWNER. The term "PROPOSER" as used throughout this document will mean the respondents to this Request for Proposal. The term "RFP" as used throughout this document will mean Request for Proposal.

2. INTENT

The OWNER is soliciting proposals for Neurosurgery On-Call Services.

3. SCOPE OF PROJECT

Background

University Medical Center of Southern Nevada, located in Las Vegas, Nevada, is a county-owned, acute-care hospital, organized under Nevada Revised Statute Chapter 450, with over 500 beds, a Level 1 Trauma Center, a Level 2 Pediatric Trauma Center and 10 urgent care clinics.

Purpose

The purpose of this RFP is to identify superior proposers to staff neurosurgery on-call services.

Expectations of Business Partner

UMC strives to provide exemplary service to its patients. UMC therefore has high expectations of its business partners. It is expected that the business partner will provide quality products and service at the lowest price available in the market, but just as important is the expectation that these products and services are provided in a manner that exhibits the highest level of ethics and professionalism. It is expected that, as a result of this relationship, the business partner will work with UMC to ensure that the agreement remains competitive with continual review of market conditions.

4. DESIGNATED CONTACTS

The OWNER's representative will be Rob Maher, telephone number (702) 207-8846. This representative will respond to questions concerning the scope of work of this RFP. Questions regarding the selection process for this RFP may be directed to Rob Maher, Contracts Management, and telephone number (702) 207-8846.

5. CONTACT WITH OWNER DURING RFP PROCESS

Communication between a PROPOSER and a member of the BCC or between a PROPOSER and a non-designated Owner contact regarding the selection of a proponent or award of this contract is prohibited from the time the RFP is advertised until the item is posted on an agenda for award of the contract. Questions pertaining to this RFP shall be addressed to the designated contact(s) specified in the RFP document. Failure of a PROPOSER, or any of its representatives, to comply with this paragraph may result in their proposal being rejected.

6. TENTATIVE DATES AND SCHEDULE

|  |                    |
|--|--------------------|
| RFP Published in Las Vegas Review-Journal  | February 10, 2013  |
| Final Date to Submit Questions             | February 15, 2013  |
| Last Day for Addendums                     | February 21, 2013  |
| RFP Responses Due (2:00 pm)                | February 28, 2013  |
| RFP Evaluations                            | March 2013         |
| Finalists Selection                        | March 2013         |
| Finalists Oral Presentations (if required) | March / April 2013 |
| Final Selection & Contract Negotiations    | March / April 2013 |
| Award & Approval of the Final Contract     | May 2013           |

7. METHOD OF EVALUATION AND AWARD

Since the service requested in this RFP is considered to be a professional service, award will be in accordance with the provisions of the Nevada Revised Statutes, Chapter 332, Purchasing: Local Governments, Section 332.115.

The proposals may be reviewed individually by staff members through an ad hoc committee. The finalists may be requested to provide the OWNER a presentation and/or an oral interview. The ad hoc staff committee may review the RFP's as well as any requested presentations and/or oral interviews to gather information that will assist in making the recommendation. The OWNER reserves the right to award the contract based on objective and/or subjective evaluation criteria. This contract will be awarded on the basis of which proposal the OWNER deems best suited to fulfill the requirements of the RFP. The OWNER also reserves the right not to make an award if it is deemed that no single proposal fully meets the requirement of this RFP. The OWNER reserves the right to make a multiple award if it is in the best interest of the OWNER.

OWNER's mission is to provide the highest quality of care to its patients. For continuity of care and other reasons, OWNER will enter into a contract for each component described. (The exception is that an attending physician on OWNER's staff may request any physician to provide a specific procedure or consultation for a patient.)

Once OWNER makes an initial selection, it will utilize required compliance considerations, and negotiate fair market value compensation for the services under the agreement. Based upon this process, OWNER will then negotiate a final contract(s) with PROPOSER and Principal Physician and present the contract(s) to the BCC for approval. A sample contract is attached hereto and incorporated by reference herein as Exhibit B.

8. SUBMITTAL REQUIREMENTS

The proposal submitted should not exceed 30 pages. Other attachments may be included with no guarantee of review.

**All proposals shall be on 8-1/2" x 11" paper bound with tabbed dividers labeled by evaluation criteria section to correspond with the evaluation criteria requested in Section 19. The ideal proposal will be 3-hole punched and bound with a binder clip. Binders or spiral binding is neither preferred nor required.**

**PROPOSER shall submit 1 clearly labeled original and 15 copies of their proposal. Additionally, PROPOSER shall submit 1 electronic copy in PDF or MS Word format on a CD. (Please do NOT submit on a flash/thumb drive.)** The name of PROPOSER's firm shall be indicated on the cover of each proposal.

**All proposals must be submitted in a sealed envelope plainly marked with the name and address of PROPOSER and the RFP number and title.** No responsibility will attach to OWNER or any official or employee thereof, for the pre-opening of, post-opening of, or the failure to open a proposal not properly addressed and identified. FAXED OR EMAILED PROPOSALS ARE NOT ALLOWED AND WILL NOT BE CONSIDERED.

The following are detailed delivery/mailling instructions for proposals:

|                               |                               |                                     |
|-------------------------------|-------------------------------|-------------------------------------|
| <u>Hand Delivery</u>          | <u>U.S. Mail Delivery</u>     | <u>Express Delivery (Preferred)</u> |
| University Medical Center     | University Medical Center     | University Medical Center           |
| Materials Management          | Materials Management          | Materials Management                |
| Trauma Center Building        | 1800 West Charleston Blvd     | 800 Rose Street, Suite 409          |
| 800 Rose Street, Suite 409    | Las Vegas, Nevada 89102       | Las Vegas, Nevada 89106             |
| Las Vegas, Nevada 89106       |                               |                                     |
| RFP No. 2013-072013-06        | RFP No. 2013-072013-06        | RFP No. 2013-072013-06              |
| Neurosurgery On-Call Services | Neurosurgery On-Call Services | Neurosurgery On-Call Services       |

Regardless of the method used for delivery, PROPOSER(S) shall be wholly responsible for the timely delivery of submitted proposals.

Proposals are time-stamped upon receipt. Proposals submitted must be time-stamped to later than 2:00:00 p.m. on the RFP opening date. RFPs time-stamped after 2:00:00 p.m., based on the time clock at the UMC Contracts Management office will be recorded as late, remain unopened and be formally rejected. PROPOSERS and other interested parties are invited to attend the RFP opening.

9. WITHDRAWAL OF PROPOSAL

PROPOSER(S) may request withdrawal of a posted, sealed proposal prior to the scheduled proposal opening time provided the request for withdrawal is submitted to the Purchasing Analyst in writing or a proposal release form has been properly filled out and submitted to the Purchasing and Contracts Division reception desk. Proposals must be re-submitted and time-stamped in accordance with the RFP document in order to be accepted.

No proposal may be withdrawn for a period of 90 calendar days after the date of proposal opening. All proposals received are considered firm offers during this period. The PROPOSER's offer will expire after 90 calendar days.

If a PROPOSER intended for award withdraws their proposal, that PROPOSER may be deemed non-responsible if responding to future solicitations.

10. REJECTION OF PROPOSAL

OWNER reserves the right to reject any and all proposals received by reason of this request.

11. PROPOSAL COSTS

There shall be no obligation for the OWNER to compensate PROPOSER(S) for any costs of responding to this RFP.

12. ALTERNATE PROPOSALS

Alternate proposals are defined as those that do not meet the requirements of this RFP. Alternate proposals will not be considered.

13. ADDENDA AND INTERPRETATIONS

If it becomes necessary to revise any part of the RFP, a written addendum will be provided to all PROPOSER(S) in written form from the Purchasing Analyst. OWNER is not bound by any specifications by OWNER's employees, unless such clarification or change is provided to PROPOSER(S) in written addendum form from the Purchasing Analyst.

14. PUBLIC RECORDS

The OWNER is a public agency as defined by state law, and as such, it is subject to the Nevada Public Records Law (Chapter 239 of the Nevada Revised Statutes). Under that law, all of the OWNER's records are public records (unless otherwise declared by law to be confidential) and are subject to inspection and copying by any person. However, in accordance with NRS 332.061(2), a proposal that requires negotiation or evaluation by the Owner may not be disclosed until the proposal is recommended for award of a contract. PROPOSER(S) are advised that once a proposal is received by the OWNER, its contents will become a public record and nothing contained in the proposal will be deemed to be confidential except proprietary information. PROPOSER(S) shall not include any information in their proposal that is proprietary in nature or that they would not want to be released to the public. Proposals must contain sufficient information to be evaluated and a contract written without reference to any proprietary information.

If a PROPOSER feels that they cannot submit their proposal without including proprietary information, they must adhere to the following procedure or their proposal may be deemed unresponsive and will not be recommended to the BCC for selection:

PROPOSER(S) must submit such information in a separate, sealed envelope labeled "Proprietary Information" with the RFP number. The envelope must contain a letter from the PROPOSER's legal counsel describing the documents in the envelope, representing in good faith that the information in each document meets the narrow definitions of proprietary information set forth in NRS 332.025, 332.061 and NRS Chapter 600A, and briefly stating the reasons that each document meets the said definitions.

Upon receipt of a proposal accompanied by such a separate, sealed envelope, the OWNER will open the envelope to determine whether the procedure described above has been followed.

Any information submitted pursuant to the above procedure will be used by the OWNER only for the purposes of evaluating proposals and conducting negotiations and might never be used at all.

If a lawsuit or other court action is initiated to obtain proprietary information, a PROPOSER(S) who submits the

## General Conditions

RFP No. 2013-07

Neurosurgery On-Call Services

proprietary information according to the above procedure must have legal counsel intervene in the court action and defend the secrecy of the information. Failure to do so shall be deemed PROPOSER's consent to the disclosure of the information by the OWNER, PROPOSER's waiver of claims for wrongful disclosure by OWNER, and PROPOSER's covenant not to sue OWNER for such a disclosure.

PROPOSER(S) also agrees to fully indemnify the OWNER if the OWNER is assessed any fine, judgment, court cost or attorney's fees as a result of a challenge to the designation of information as proprietary.

### 15. PROPOSALS ARE NOT TO CONTAIN CONFIDENTIAL / PROPRIETARY INFORMATION

Proposals must contain sufficient information to be evaluated and a contract written without reference to any confidential or proprietary information. PROPOSER(S) shall not include any information in their proposal that they would not want to be released to the public. Any proposal submitted that is marked "Confidential" or "Proprietary," or that contains materials so marked, will be returned to the PROPOSER and will not be considered for award.

### 16. COLLUSION AND ADVANCE DISCLOSURES

Pursuant to 332.165 evidence of agreement or collusion among PROPOSER(S) and prospective PROPOSER(S) acting to illegally restrain freedom of competition by agreement to bid a fixed price, or otherwise, shall render the offers of such PROPOSER(S) void.

Advance disclosures of any information to any particular PROPOSER(S) which gives that particular PROPOSER any advantage over any other interested PROPOSER(S), in advance of the opening of proposals, whether in response to advertising or an informal request for proposals, made or permitted by a member of the governing body or an employee or representative thereof, shall operate to void all proposals received in response to that particular request for proposals.

### 17. CONTRACT

A sample of the OWNER's Standard Contract is attached. Any proposed modifications to the terms and conditions of the Standard Contract are subject to review and approval by the Clark County District Attorney's Office.

### 18. CLARK COUNTY BUSINESS LICENSE / REGISTRATION

Prior to award of this RFP, other than for the supply of goods being shipped directly to a Clark County facility, the successful CONSULTANT will be required to obtain a Clark County business license or register annually as a limited vendor business with the Clark County Business License Department.

#### a. Clark County Business License is required if:

1. A business is physically located in unincorporated Clark County, Nevada.
2. The work to be performed is located in unincorporated Clark County, Nevada.

#### b. Register as a Limited Vendor Business Registration is required if:

1. A business is physically located outside of unincorporated Clark County, Nevada
2. A business is physically located outside the state of Nevada.

The Clark County Department of Business License can answer any questions concerning determination of which requirement is applicable to your firm. It is located at the Clark County Government Center, 500 South Grand Central Parkway, 3<sup>rd</sup> Floor, Las Vegas, NV or you can reach them via telephone at (702) 455-4253 or toll free at (800) 328-4813.

You may also obtain information on line regarding Clark County Business Licenses by visiting the website at [www.accessclarkcounty.com](http://www.accessclarkcounty.com), select "Online Services", then select "Business License Inquire" or by the browser search <http://sandgate.co.clark.nv.us/businessLicense/businessSearch/blindex.asp>

### 19. EVALUATION CRITERIA

Proposals should contain the following information:

#### A. **Organizational Information**

1. Provide your organization's name, address, internet URL (if any), telephone and fax numbers. Include the name, title, direct phone number and address, and E-mail address of the individual who will serve as your organization's primary contact.

2. Provide a brief description of your organization locally, statewide and nationally (if applicable).
3. List the names of all physicians associated with your organization.
4. List the names, specialties and locations of all physicians who will be providing services under this agreement.
5. Provide a Curriculum Vitae for each such physician. Include current activity at University Medical Center beyond staff privileges, i.e. committee memberships, teaching, etc. Include membership in national organizations and committee membership on the national level. This can be an abbreviated CV.
6. List teaching experience.
7. List all actions required to be reported pursuant to NRS 630.3067 or NRS 633.526 within the last ten (10) years.
8. List any other factor known to PROPOSER that could materially impair the ability of PROPOSER to carry out its duties and obligations under this Agreement or that could materially affect Owner's decision.
9. List all medical facilities for which any of the physicians listed in sections 3 or 4 hold a medical staff position or department directorship.
10. All firms may indicate if they are a minority-owned business, women-owned business, physically-challenged business, small business, or a Nevada business enterprise.
11. State the total number of physicians in terms of Full Time Equivalents (FTE's) who will be devoted to the provision of services under this Agreement.
12. List all firm demographics including:
  - Total number of employees
  - Total number of women employed
  - Total number of minorities employed
  - Total number of bilingual employees, indicate language(s) spoken
  - Total number of employees living in Las Vegas, Nevada area
13. Disclose any potential conflict of interest between your company and any sales agent of products sold to UMC.
14. Complete and submit the attached Disclosure of Ownership/Principals form and the Disclosure of Relationship form with its proposal.

**B. Healthcare Experience**

1. Document your organization's credentials, experience, and involvement in Neurosurgery care and treatment.
2. Detail your organization's experience working with other large Medical Centers and/or Healthcare Systems.
3. List your organization's capabilities to manage costs and success at passing on these efficiencies to your clients.
4. Provide a list of four (4) references with contact information, including email addresses.

**C. Services Management**

This section shall serve to provide the OWNER with the key elements and unique features of the proposal by briefly describing how the PROPOSER is going to provide the services requested in accordance with the Scope



of Project.

1. How would your organization service UMC? What methods of communication would your company propose?
2. What is your organization's implementation plan for providing Neurosurgery services under this agreement?
3. Please describe how your organization measures and reports client satisfaction and service success. How can clients make comments on your organization's service?
4. Provide a couple examples of how you and your team could and will boost revenue for the hospital.
5. Describe how you would ensure 24/7/365 coverage for neurosurgery and spine services.
6. How do you balance physician preference items with supply cost saving initiatives?
7. Explain how would you adhere to core measurement requirements?
8. Describe how would you adhere to surgical requirements such as time-outs, pre-op and post-op assessments?
9. Provide and explain a matrix that is typical in assessing the performance of neurosurgeons.
10. What is the most critical characteristic of a Neurosurgeon that makes him/her successful?

**D. Fee**

1. Please set forth your proposed monthly fee for:
  - a. Neurosurgery On-Call Services
  - b. Spine On-Call Services

**E. Compliance with the OWNER'S Standard Contract**

Indicate any exceptions that your firm would have to take in order to accept the attached Standard Contract. PROPOSER(S) are advised that any exception that is determined to be material may be grounds for elimination in the selection process.

**F. Other**

Other factors the PROPOSER determines appropriate which would indicate to the OWNER that the PROPOSER has the necessary capability, competence, and performance record to accomplish the project in a timely and cost-effective manner.

## **Exhibit A**

### **SCOPE OF PROJECT**

- I. Provider and Principal Physician – General Requirements
  1. Principal Physician must hold at all times a current license as a neurosurgeon from the American Board of Neurological Surgery. The Principal Physician's back up physician must also be board certified or eligible in Neurological Surgery.
  2. No Member Physician may be an "Excluded Provider" from any federally funded healthcare program.
  3. All Member Physicians must be licensed to practice medicine within the State of Nevada. All licenses must be unrestricted and in good standing.
  4. The Principal Physician shall act as the liaison with Hospital and its Medical Staff to resolve patient care issues.
- II. Provider Staffing
  1. All staff must obtain medical staff privileges at University Medical Center of Southern Nevada
  2. All staff must carry malpractice insurance coverage at their own expense in accordance with the minimums established by the Bylaws, Rules and Regulations of the Medical and Dental Staff. Said insurance shall annually be certified to Hospital's Administrator and Medical Staff, as necessary.
  3. All staff must be eligible to be credentialed by and contract with various managed care plans with which Owner has a contract.
  4. All staff must agree to follow all University Medical Center policies and the Bylaws, Rules and Regulations of the Medical Staff.
  5. All staff must also meet all legal and licensing requirements set forth by the State of Nevada and Clark County.
- III. Duties – General
  1. Provider shall provide professional services in the best interests of Hospital's patients with all due diligence.
  2. Provider will provide Services so that a Physician is present when required for delivery of Services to Patients. Provider shall consult with the Medical Staff of Hospital when requested.
  3. Except as otherwise provided in subsection 4 below, Provider shall provide Hospital with consultative coverage in accordance with the Bylaws, Rules and Regulations of the Medical and Dental Staff. For this purpose consultative coverage consists of patient examination/assessment, diagnosis, medical/surgical intervention and follow-up care. This coverage includes all Hospital inpatients, Hospital outpatients, Emergency Department patients and Trauma Department patients who are not designated patients of other physicians unless resident coverage has been assigned to another group or physician on a predetermined and agreed upon scheduled rotation.
  4. Provider shall provide service on an emergency and on-call basis to meet the needs of Hospital's inpatients and outpatients.
  5. Provider shall coordinate the schedules and assignments of the physicians assigned to Services. At no time will Services be without coverage.
  6. Provider shall encourage the participation of other physicians in the community to assist Provider in the provision of the services outlined in this Agreement.
  7. Primary Physician, their team or group shall submit at least one (1) annual peer review publication.

IV. Duties – Teaching

Provide for the education of Medical Staff and Hospital personnel, residents and medical students in a defined organized structure and as the need presents itself.

V. Managed Care Organizations

All Member Physicians must be eligible to be credentialed by and contract with various managed care plans with which Hospital has a contract.

VI. Billing

Successful Provider shall directly bill patients and/or third party payors for all professional components. Hospital shall provide, at Hospital's expense, usual social security and insurance information to facilitate direct billing. Hospital is not responsible for the billing or collection of professional components.

VII. Independent Contractor

The successful Provider represents that it is fully experienced and properly qualified to perform the class of work provided for herein, that it is properly licensed, equipped, organized and financed to fulfill all requirements. The successful Provider shall act as an independent contractor and not as the agent of Hospital in performing the contract. The successful Provider/Respondent shall maintain complete control over its employees and shall perform all work in accordance with its own methods subject to compliance with the Contract.

## HOSPITAL DEMOGRAPHIC DATA NEUROSURGERY

### Hospital's Overall Data

| Payor Mix                            | FY 2010 | FY 2011 |
|--------------------------------------|---------|---------|
| Clark County Self Funded             | 10.9%   | 10.9%   |
| Health Services Purchasing Coalition | 2.0%    | 1.4%    |
| Governmental (Tricare, etc)          | 1.4%    | 3.6%    |
| PPO                                  | 17.2%   | 14.8%   |
| Sierra                               | 1.1%    | 2.6%    |
| Private Insurance                    | 7.6%    | 6.8%    |
| Medicaid                             | 7.7%    | 8.0%    |
| Medicaid HMO                         | 2.2%    | 2.6%    |
| Medicare                             | 12.5%   | 13.8%   |
| Medicare HMO                         | 6.2%    | 5.9%    |
| Pending Medicaid                     | 8.7%    | 8.8%    |
| Self-Pay                             | 18.1%   | 19.9%   |
| Worker's Comp                        | 1.6%    | 1.0%    |

### Neurology Cases 2010

| Paysource                   | Total Number of Visits | Total Amount of Charges |
|-----------------------------|------------------------|-------------------------|
| Self Pay                    | 120                    | \$6,365,347.97          |
| Clark County Social Service | 37                     | \$1,691,586.21          |
| Medicaid                    | 121                    | \$12,805,229.12         |
| Medicare                    | 166                    | \$11,775,285.80         |
| Other Governmental          | 25                     | \$2,282,708.41          |
| Workman's Comp              | 12                     | \$947,259.51            |
| HMO, PPO, COMM              | 196                    | \$15,480,290.23         |
| Grand Total                 | 677                    | \$51,347,707.25         |

### 2011

| Paysource                   | Total Number of Visits | Total Amount of Charges |
|-----------------------------|------------------------|-------------------------|
| Self Pay                    | 126                    | \$8,089,845.78          |
| Clark County Social Service | 50                     | \$3,027,135.73          |
| Medicaid                    | 127                    | \$13,850,226.57         |
| Medicare                    | 168                    | \$9,632,720.51          |
| Other Governmental          | 24                     | \$1,810,212.57          |
| Workman's Comp              | 12                     | \$1,055,068.29          |
| HMO, PPO, COMM              | 217                    | \$14,269,168.00         |
| Grand Total                 | 724                    | \$51,734,377.45         |

**Exhibit B**

**Sample Contract**

**AGREEMENT FOR PHYSICIAN PROFESSIONAL SERVICES**

This Agreement, made and entered into this \_\_\_\_ day of \_\_\_\_\_, 2013, by and between **University Medical Center of Southern Nevada**, a publicly owned and operated hospital created by virtue of Chapter 450 of the Nevada Revised Statutes (hereinafter referred to as “Hospital”) and \_\_\_\_\_, a professional corporation, engaged in the practice of neurosurgery existing under and by virtue of the laws of the State of Nevada, with its principal place of business at \_\_\_\_\_, Las Vegas, NV 89XXX (hereinafter referred to as the “Provider”);

**WHEREAS**, Hospital provides neurosurgery specialist service which requires professional medical services; and

**WHEREAS**, Hospital recognizes that the proper functioning of the same requires a service coverage agreement from a physician who has been properly trained and is fully qualified and competent to practice medicine as a neurosurgery specialist; and

**WHEREAS**, Provider desires to contract for and provide said professional medical services; and

**WHEREAS**, the parties desire to provide a full statement of their agreement.

**NOW THEREFORE**, in consideration of the covenants and mutual promises made herein, the parties agree as follows:

**I. DEFINITIONS**

For the purposes of this Agreement, the following definitions apply:

- 1.1 Advanced Practice Professional. Individuals licensed as Physician Assistants (“PA”), Advanced Practitioners of Nursing (“APN”), or Certified Nurse Midwife who exercise independent or dependent judgment within the areas of their scope of practice and who are qualified to render patient care services under the supervision of a qualified physician who has been accorded privileges to provide such care in Hospital.
- 1.2 Allied Health Providers. Individuals other than a licensed physician, M.D., D.O. or dentist who exercise independent or dependent judgment within the areas of their

scope of practice and who are qualified to render patient care services under the supervision of a qualified physician who has been accorded privileges to provide such care in Hospital.

- 1.3 Clinical Services. Services performed for the diagnosis, prevention or treatment of disease or for assessment of a medical condition.
- 1.4 Department. Unless the context requires otherwise, Department refers to Hospital's Department of Neurosurgery.
- 1.5 Member Physicians. Physicians associated with Provider who provide services pursuant to this Agreement. Unless the context requires otherwise, the term "Member Physicians" shall include the Principal Physician.
- 1.6 Principal Physician.
- 1.7 Provider.
- 1.8 Services to Hospital. Those services which do not qualify as "Services to Patients" as herein defined, but which are services provided by Provider to Hospital and are related to the provision of patient care in Hospital; including, but not limited to, administrative and supervisory services. Clinical services which do not meet the requirements of "Services to Patients" shall be considered "Services to Hospital."
- 1.9 Services to Patients. Those services personally rendered by Provider's Member Physicians to the patient.
  - a. To qualify as "Services to Patients", services must, in general: (i) be personally furnished by Provider's Member Physicians; (ii) contribute directly to the diagnosis or treatment of the patient; and (iii) ordinarily require performance by a physician.
  - b. Services to Patients include: (i) consultative services; and (ii) services personally performed by Provider's Member Physicians in the administration of procedures to an individual patient.

## **II. PROVIDER'S OBLIGATIONS**

- 2.1 Coverage. Provider, through its Member Physicians hereby agrees to perform the following services as requested by Hospital and in a manner reasonably satisfactory to Hospital:

- a. Provider shall provide Hospital with coverage on a twenty-four (24) hour a-day, seven (7) day-a-week basis. Provider shall respond to all requests for consultations as follows:

- Emergency response: Provider shall be on site within twenty (20) minutes.
- Routine consultations: Provider shall respond within eight (8) hours.
- Response time shall be five (5) minutes call back by telephone when paged.

For this purpose consultative coverage consists of patient examination/assessment, diagnosis, medical/surgical intervention and follow-up care. This coverage includes all Hospital inpatients, Emergency Department patients and Trauma Department patients who are not designated patients of other physicians unless resident coverage has been assigned to another group or physician on a predetermined and agreed upon scheduled rotation.

- b. Provider shall provide professional services in the best interests of Hospital's patients with all due diligence.
- c. Provider shall provide service on an emergency and an as needed basis to meet the needs of Hospital's inpatients and outpatients.
- d. Provider may have a teaching role within UMC.
- e. Provider shall abide by UMC's Physician Code of Conduct.
- f. Provider shall adhere to all the Standards of Performance and Deliverables identified in **Attachments "A", "B", "C", "D", "E" and "F"**.

## 2.2 Medical Staff Appointment.

- a. Member Physicians employed or contracted by Provider shall at all times hereunder, be members in good standing of Hospital's medical staff with appropriate clinical privileges and appropriate Hospital credentialing. Any of Provider's Member Physicians who fail to maintain staff appointment of clinical privileges in good standing will not be permitted to render services to Hospital's patients and will be replaced promptly by Provider. Provider shall replace a Member Physician who is suspended, terminated or expelled from Hospital's Medical Staff, loses his license to practice medicine, tenders his resignation, or violates the terms of this Agreement. In the event Provider replaces or adds a Member Physician, such new physician shall meet all of the conditions set forth herein, and shall agree in writing to be bound by the terms of this Agreement. In the event an appointment to the Medical Staff is

granted solely for purposes of this Agreement, such appointment shall automatically terminate upon termination of this Agreement.

- b. It is expressly agreed that continuation of this Agreement is dependent upon the continued appointment of \_\_\_\_\_ as Provider's Principal Physician.
- c. Provider shall be fully responsible for the performance and supervision of any of its Member Physicians, including its Principal Physician, or others under its direction and control, in the performance of services under this Agreement.
- d. Allied Health Providers employed or utilized by Provider, if any, must apply for privileges and remain in good standing in accordance with the University Medical Center of Southern Nevada Allied Health Providers Manual.

2.3 Principal Physician. Provider's Principal Physician shall at all times during the term of this Agreement;

- a. be Board Certified;
- b. possess an active license to practice medicine from the State of Nevada which is in good standing; and
- c. not be subject to any agreement or understanding, written or oral, that the Principal Physician will not engage in the practice of medicine, either temporarily or permanently.

Hospital shall, in its discretion, have the right to terminate this Agreement if Principal Physician fails to meet any of the foregoing requirements in this section.

2.4 Other Responsibilities.

- a. Contribute to a positive relationship among Hospital's Administration, Health Care Providers (RN's, ancillary providers), Hospital's Medical Staff and the community;
- b. Promote the growth and development of the Services in conjunction with Hospital with special emphasis on expanding diagnostic and therapeutic services;
- c. Inform the Medical Staff of new equipment and applications;



- d. Recommend innovative changes directed toward improved patient services;
- e. Develop and implement guidelines, policies and procedures in accordance with recognized professional medical specialty standards and the requirements of local, state and national regulatory agencies and accrediting bodies;
- f. Recommend the selection and development of appropriate methods, instrumentation and supplies to assure proper utilization of staff and efficient reporting of results;
- g. Represent the Services on Hospital's medical staff committees and at Hospital department meetings as the need arises;
- h. Participate in Quality Assurance and Performance Improvement activities by monitoring and evaluating care; communicating findings, conclusions, recommendations and actions taken; and using established Hospital mechanisms for appropriate follow-up;
- i. Assess and recommend to Hospital's Administration the need for capital expenditure for equipment, supplies and space required to maintain and expand the Services;
- j. Provide for the education of Medical Staff and Hospital personnel, residents and medical students in a defined organized structure and as the need presents itself;
- k. Monitor the use of equipment and report any malfunction to Hospital Administration;
- l. Assist Hospital in the appeal of any denial of payment of Hospital charges;
- m. Assist Hospital's Administration with the performance of such other duties as necessary to operate the Services;
- n. Sustain and support resident fellow rotations for University of Nevada School of Medicine.
- o. Must see all patients that require follow-up visits in Provider's office regardless of patient's ability to make up-front payments or deposits;
- p. Use best efforts to use Hospital's contracted anesthesiologists and hospitalists; and

- q. Provide for a positive and collaborative work environment for all disciplines caring for patients.
- r. Provider shall utilize the products currently on contract with UMC. New or “wish list” items may be brought to the Value Analysis Facilitator for consideration.

2.5 Independent Contractor. In the performance of the work duties and obligations performed by Provider under this Agreement, it is mutually understood and agreed that Provider is at all times acting and performing as an independent contractor practicing the profession of medicine. Hospital shall neither have, nor exercise any, control or direction over the methods by which Provider shall perform its work and functions.

2.6 Industrial Insurance.

- a. As an independent contractor, Provider shall be fully responsible for premiums related to accident and compensation benefits for its shareholders and/or direct employees as required by the industrial insurance laws of the State of Nevada.
- b. Provider agrees, as a condition precedent to the performance of any work under this Agreement and as a precondition to any obligation of Hospital to make any payment under this Agreement, to provide Hospital with a certificate issued by the appropriate entity in accordance with the industrial insurance laws of the State of Nevada. Provider agrees to maintain coverage for industrial insurance pursuant to the terms of this Agreement. If Provider does not maintain such coverage, Provider agrees that Hospital may withhold payment, order Provider to stop work, suspend the Agreement or terminate the Agreement.

2.7 Professional Liability Insurance. Provider shall carry professional liability insurance on its Member Physicians and employees at its own expense in accordance with the minimums established by the Bylaws, Rules and Regulations of the Medical and Dental Staff. Said insurance shall annually be certified to Hospital’s Administration and Medical Staff, as necessary.

2.8 Provider Personal Expenses. Provider shall be responsible for all its personal expenses, including, but not limited to, membership fees, dues and expenses of attending conventions and meetings, except those specifically requested and designated by Hospital.

2.9 Maintenance of Records.

- a. All medical records, histories, charts and other information regarding patients treated or matters handled by Provider hereunder, or any data or data bases derived therefrom, shall be the property of Hospital regardless of the manner, media or system in which such information is retained. Provider shall have access to and may copy relevant records upon reasonable notice to Hospital.
- b. Provider shall complete all patient charts in a timely manner in accordance with the standards and recommendations of The Joint Commission and Regulations of the Medical and Dental Staff, as may then be in effect.
- c. Providers shall be 100% compliant with all SCIP Initiatives.

2.10 Health Insurance Portability and Accountability Act of 1996.

- a. For purposes of this Agreement, “Protected Health Information” shall mean any information, whether oral or recorded in any form or medium, that: (i) was created or received by either party; (ii) relates to the past, present, or future physical condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual; and (iii) identifies such individual.
- b. Provider shall use its reasonable efforts to preserve the confidentiality of Protected Health Information it receives from Hospital, and shall be permitted only to use and disclose such information to the extent that Hospital is permitted to use and disclose such information pursuant to the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d-1329d-8; 42 U.S.C. 1320d-2) (“HIPAA”), regulations promulgated thereunder (“HIPAA Regulations”) and applicable state law. Hospital and Provider shall be an Organized Health Care Arrangement (“OHCA”), as such term is defined in the HIPAA Regulations.
- c. Hospital shall, from time to time, obtain applicable privacy notice acknowledgments and/or authorizations from patients and other applicable persons, to the extent required by law, to permit the Hospital, Provider and their respective employees and other representatives, to have access to and use of Protected Health Information for purposes of the OHCA. Hospital and Provider shall share a common patient’s Protected Health Information to enable the other party to provide treatment, seek payment, and engage in quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, case management,

conducting training programs, and accreditation, certification, licensing or credentialing activities, to the extent permitted by law or by the HIPAA Regulations.

- 2.11 UMC Policy #I-66. Provider shall ensure that its staff and equipment utilized at Hospital, if any, are at all times in compliance with University Medical Center Policy #I-66, set forth in **Attachment "A"**, incorporated and made a part hereof by this reference.

### III. HOSPITAL'S OBLIGATIONS

#### 3.1 Space, Equipment and Supplies.

- a. Hospital shall provide space within Hospital for the Department (excluding Provider's private office space); however, Provider shall not have exclusivity over any space or equipment provided therein and shall not use the space or equipment for any purpose not related to the proper functioning of the Department.
- b. Hospital shall make available during the term of the Agreement such equipment as is determined by Hospital to be required for the proper operation and conduct of the Department. Hospital shall also keep and maintain said equipment in good order and repair.
- c. Hospital shall purchase all necessary supplies for the proper operation of the Department and shall keep accurate records of the cost thereof.

- 3.2 Hospital Services. Hospital shall provide the services of other hospital departments including, but not limited to, Accounting, Administration, Engineering, Human Resources, Material Management, Medical Records and Nursing.

- 3.3 Personnel. Other than Member Physicians and Allied Health Providers, all personnel required for the proper operation of the Department shall be employed by Hospital. The selection and retention of such personnel shall be in cooperation with Principal Physician, but Hospital shall have final authority with respect to such selection and retention. Salaries and personnel policies for persons within personnel classifications used in Department shall be uniform with other Hospital personnel in the same classification insofar as may be consistent with the recognized skills and/or hazards associated with that position, providing that recognition and compensation be provided for personnel with special qualifications in accordance with the personnel policies of Hospital.

- 3.4 Exclusivity of Services. This Agreement does not preclude an attending physician on Hospital's Staff from requesting a specific physician, not a party to this Agreement, to provide a specific procedure or consultation in the Department, subject to Provider's right to schedule all department procedures and services and provided that such independent physician is a member of Hospital's Medical Staff.

#### **IV. COMPENSATION**

- 4.1 During the term of this Agreement and subject to paragraph 6.6, hereinbelow, Hospital will compensate Provider \$\_\_\_\_\_per day for Neurosurgery On-Call services provided during the month on the third (3rd) Friday of each following month, or if the third (3rd) Friday falls on a holiday, the following Monday.

#### **V. TERM/MODIFICATIONS/TERMINATION**

- 5.1 Term of Agreement. This Agreement shall become effective on the 1<sup>st</sup> day of July, 2013, and, subject to paragraph 6.6, hereinbelow, shall remain in effect through June 30, 2016 with two (2) one (1) year options.

- 5.2 Modifications. Provider shall notify Hospital in writing of:

- a. Any change of address of Provider;
- b. Any change in membership or ownership of Provider's group or Professional Corporation.
- c. Any action against the license of any of Provider's Member Physicians;
- d. Any action commenced against Provider which could materially affect this Agreement;
- e. Any exclusionary action initiated or taken by a federal health care program against Provider or any of Provider's Member Physicians; or
- f. Any other occurrence known to Provider that could materially impair the ability of Provider to carry out its duties and obligations under this Agreement.

- 5.3 Termination For Cause.

- a. This Agreement shall immediately terminate upon written notice by Hospital, upon the occurrence of any one of the following events:

1. The exclusion of Provider from participation in a federal health care program;
  2. The expulsion, termination or suspension of Provider's Principal Physician by Hospital's Medical Staff or loss of Provider's Principal Physician's license to practice medicine unless Provider provides a substitute physician who is satisfactory to Hospital, as determined by Hospital's Administration in consultation with the Medical Executive Committee. [Hospital will not unreasonably withhold such acceptance/approval.]; or
  3. The conviction of Provider's Principal Physician of any crime punishable as a felony involving moral turpitude or immoral conduct unless Provider provides a substitute physician who is satisfactory to Hospital, as determined by Hospital's Administration in consultation with the Medical Executive Committee. [Hospital will not unreasonably withhold such acceptance/approval.].
- b. The Agreement may be terminated immediately by Hospital upon written notice by Hospital, upon the occurrence of any of the following events unless Provider provides a substitute physician who is satisfactory to Hospital, as determined by Hospital's Administration in consultation with the Medical Executive Committee. [Hospital will not unreasonably withhold such acceptance/approval.]:
1. Principal Physician loses Board Certification; or
  2. Principal Physician's license to practice medicine from the State of Nevada is suspended, revoked or otherwise loses good standing; or
  3. The Principal Physician is subject to any agreement or understanding, written or oral, that the Principal Physician will not engage in the practice of medicine, either temporarily or permanently; or
  4. Provider's or Principal Physician's business license has been suspended or revoked; or
  5. The Principal Physician is subject to any court order that restricts or prohibits him/her from practicing medicine, either temporarily or permanently.
- c. This Agreement may be terminated by Hospital at any time with thirty (30) days written notice, upon the occurrence of any one of the following events

which has not been remedied within thirty (30) days after written notice of said breach:

1. Professional misconduct by any of Provider's Member Physicians as determined by the Bylaws, Rules and Regulations of the Medical and Dental Staff and the appeal processes thereunder; or
  2. Conduct by any of Provider's Member Physicians which demonstrates an inability to work with others in the institution and such behavior presents a real and substantial danger to the quality of patient care provided at the facility as determined by Hospital; or
  3. Disputes among the Member Physicians, partners, owners, principals, or of Provider's group or professional corporation that, in the reasonable discretion of Hospital, are determined to disrupt the provision of good patient care; or
  4. Absence of Provider's Principal Physician, by reason of illness or other cause, for a period of ninety (90) days, unless adequate coverage is furnished by Provider. Such adequacy will be determined by Hospital's Administration; or
  5. Breach of any material term or condition of this Agreement.
- d. This Agreement may be terminated by Provider at any time with thirty (30) days written notice, upon the occurrence of any one of the following events which has not been remedied within said thirty (30) days written notice of said breach:
1. The exclusion of Hospital from participation in a federal health care program; or
  2. The loss or suspension of Hospital's licensure or any other certification or permit necessary for Hospital to provide services to patients; or
  3. The failure of Hospital to maintain full accreditation by The Joint Commission; or
  4. Failure of Hospital to cooperate with Provider in the billing process as set forth in Section IV, above; or

5. Failure of Hospital to compensate Provider in a timely manner as set forth in Section IV, above; or
  6. Breach of any material term or condition of this Agreement.
- 5.4 Termination Without Cause. Either party may terminate this Agreement, without cause, upon one hundred eighty (180) days written notice to the other party. If Hospital terminates this Agreement, Provider waives any cause of action or claim for damages arising out of or related to the termination.

## **VI. MISCELLANEOUS**

- 6.1 Access to Records. Upon written request of the Secretary of Health and Human Services or the Comptroller General or any of their duly authorized representatives, Provider shall, for a period of four (4) years after the furnishing of any service pursuant to this Agreement, make available to them those contracts, books, documents, and records necessary to verify the nature and extent of the costs of providing its services. If Provider carries out any of the duties of this Agreement through a subcontract with a value or cost equal to or greater than \$10,000 or for a period equal to or greater than twelve (12) months, such subcontract shall include this same requirement. This section is included pursuant to and is governed by the requirements of the Social Security Act, 42 U.S.C. ' 1395x (v) (1) (I), and the regulations promulgated thereunder.
- 6.2 Amendments. No modifications or amendments to this Agreement shall be valid or enforceable unless mutually agreed to in writing by the parties.
- 6.3 Assignment/Binding on Successors. No assignment of rights, duties or obligations of this Agreement shall be made by either party without the express written approval of a duly authorized representative of the other party. Subject to the restrictions against transfer or assignment as herein contained, the provisions of this Agreement shall inure to the benefit of and shall be binding upon the assigns or successors-in-interest of each of the parties hereto and all persons claiming by, through or under them.
- 6.4 Audits. The performance of this contract by the Provider is subject to review by the Hospital to insure contract compliance. The Provider agrees to provide the Hospital any and all information requested that relates to the performance of this contract. All requests for information shall be in writing to the Provider. Time is of the essence during the audit process. Failure to provide the information requested within the timeline provided in the written information request may be considered a material breach of contract and be cause for suspension and/or termination of the contract.



- 6.5 Authority to Execute. The individuals signing this Agreement on behalf of the parties have been duly authorized and empowered to execute this Agreement and by their signatures shall bind the parties to perform all the obligations set forth in this Agreement.
- 6.6 Budget Act and Fiscal Fund Out. In accordance with the Nevada Revised Statutes (NRS 354.626), the financial obligations under this Agreement between the parties shall not exceed those monies appropriated and approved by Hospital for the then current fiscal year under the Local Government Budget Act. This Agreement shall terminate and Hospital's obligations under it shall be extinguished at the end of any of Hospital's fiscal years in which Hospital's governing body fails to appropriate monies for the ensuing fiscal year sufficient for the payment of all amounts which could then become due under this Agreement. Hospital agrees that this section shall not be utilized as a subterfuge or in a discriminatory fashion as it relates to this Agreement. In the event this section is invoked, this Agreement will expire on the 30th day of June of the current fiscal year. Termination under this section shall not relieve Hospital of its obligations incurred through the 30th day of June of the fiscal year for which monies were appropriated.
- 6.7 Captions/Gender/Number. The articles, captions, and headings herein are for convenience and reference only and should not be used in interpreting any provision of this Agreement. Whenever the context herein requires, the gender of all words shall include the masculine, feminine and neuter and the number of all words shall include the singular and plural.
- 6.8 Confidential Records. All medical records, histories, charts and other information regarding patients, all Hospital statistical, financial, confidential, and/or personnel records and any data or data bases derived therefrom shall be the property of Hospital regardless of the manner, media or system in which such information is retained. All such information received, stored or viewed by Provider shall be kept in the strictest confidence by Provider and its employees and contractors.
- 6.9 Corporate Compliance. Provider recognizes that it is essential to the core values of Hospital that its contractors conduct themselves in compliance with all ethical and legal requirements. Therefore, in performing its services under this contract, Provider agrees at all times to comply with all applicable federal, state and local laws and regulations in effect during the term hereof and further agrees to use its good faith efforts to comply with the relevant compliance policies of Hospital, including its corporate compliance program and Code of Ethics, the relevant portions of which are available to Provider upon request.
- 6.10 Entire Agreement. This document constitutes the entire agreement between the parties, whether written or oral, and as of the effective date hereof, supersedes all

other agreements between the parties which provide for the same services as contained in this Agreement. Excepting modifications or amendments as allowed by the terms of this Agreement, no other agreement, statement, or promise not contained in this Agreement shall be valid or binding.

6.11 False Claims Act.

- a. The state and federal False Claims Act statutes prohibit knowingly or recklessly submitting false claims to the Government, or causing others to submit false claims. Under the False Claims Act, a provider may face civil prosecution for knowingly presenting reimbursement claims: (1) for services or items that the provider knows were not actually provided as claimed; (2) that are based on the use of an improper billing code which the provider knows will result in greater reimbursement than the proper code; (3) that the provider knows are false; (4) for services represented as being performed by a licensed professional when the services were actually performed by a non-licensed person; (5) for items or services furnished by individuals who have been excluded from participation in federally-funded programs; or (6) for procedures which the provider knows were not medically necessary. Violation of the civil False Claims Act may result in fines of up to \$11,000 for each false claim, treble damages, and possible exclusion from federally-funded health programs. Accordingly, all employees, volunteers, medical staff members, vendors, and agency personnel are prohibited from knowingly submitting to any federally or state funded program a claim for payment or approval that includes fraudulent information, is based on fraudulent documentation or otherwise violates the provisions described in this paragraph.
- b. Hospital is committed to complying with all applicable laws, including but not limited to Federal and State False Claims statutes. As part of this commitment, Hospital has established and will maintain a Corporate Compliance Program, has a Corporate Compliance Officer, and operates an anonymous 24-hour, seven-day-a-week compliance Hotline. A Notice Regarding False Claims and Statements is attached to this Agreement as **Attachment “B”**. Provider is expected to immediately report to Hospital’s Corporate Compliance Officer directly at (702) 383-6211, through the Hotline (888) 691-0772, or the website at <http://umcsn.alertline.com>, or in writing, any actions by a medical staff member, Hospital vendor, or Hospital employee which Provider believes, in good faith, violates an ethical, professional or legal standard. Hospital shall treat such information confidentially to the extent allowed by applicable law, and will only share such information on a bona fide need to know basis. Hospital is prohibited by law from retaliating in any way against any individual who, in good faith,

reports a perceived problem.

- 6.12 Federal, State, Local Laws. Provider will comply with all federal, state and local laws and/or regulations relative to its activities in Clark County, Nevada.
- 6.13 Financial Obligation. Provider shall incur no financial obligation on behalf of Hospital without prior written approval of Hospital or the Board of Hospital Trustees or its designee.
- 6.14 Force Majeure. Neither party shall be liable for any delays or failures in performance due to circumstances beyond its control.
- 6.15 Governing Law. This Agreement shall be construed and enforced in accordance with the laws of the State of Nevada.
- 6.16 Indemnification. Provider shall indemnify and hold harmless, Hospital, its officers and employees from any and all claims, demands, actions or causes of action, of any kind or nature, arising out of the negligent or intentional acts or omissions of Provider, its employees, representatives, successors or assigns. Provider shall resist and defend at its own expense any actions or proceedings brought by reason of such claim, action or cause of action.
- 6.17 Interpretation. Each party hereto acknowledges that there was ample opportunity to review and comment on this Agreement. This Agreement shall be read and interpreted according to its plain meaning and any ambiguity shall not be construed against either party. It is expressly agreed by the parties that the judicial rule of construction that a document should be more strictly construed against the drafterperson thereof shall not apply to any provision of this Agreement.
- 6.18 Non-Discrimination. Provider shall not discriminate against any person on the basis of age, color, disability, sex, handicapping condition (including AIDS or AIDS related conditions), disability, national origin, race, religion, sexual orientation, gender identity or expression, or any other class protected by law or regulation.
- 6.19 Notices. All notices required under this Agreement shall be in writing and shall either be served personally or sent by certified mail, return receipt requested. All mailed notices shall be deemed received three (3) days after mailing. Notices shall be mailed to the following addresses or such other address as either party may specify in writing to the other party:

To Hospital: Chief Executive Officer  
University Medical Center of Southern Nevada  
1800 West Charleston Boulevard

Las Vegas, Nevada 89102

To Provider:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- 6.20 Publicity. Neither Hospital nor Provider shall cause to be published or disseminated any advertising materials, either printed or electronically transmitted which identify the other party or its facilities with respect to this Agreement without the prior written consent of the other party.
- 6.21 Performance. Time is of the essence in this Agreement.
- 6.22 Severability. In the event any provision of this Agreement is rendered invalid or unenforceable, said provision(s) hereof will be immediately void and may be renegotiated for the sole purpose of rectifying the error. The remainder of the provisions of this Agreement not in question shall remain in full force and effect.
- 6.23 Third Party Interest/Liability. This Agreement is entered into for the exclusive benefit of the undersigned parties and is not intended to create any rights, powers or interests in any third party. Hospital and/or Provider, including any of their respective officers, directors, employees or agents, shall not be liable to third parties by any act or omission of the other party.
- 6.24 Waiver. A party's failure to insist upon strict performance of any covenant or condition of this Agreement, or to exercise any option or right herein contained, shall not act as a waiver or relinquishment of said covenant, condition or right nor as a waiver or relinquishment of any future right to enforce such covenant, condition or right.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed on the day and year first above written.

Provider:

\_\_\_\_\_

By: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Hospital:

**University Medical Center  
of Southern Nevada**

By: \_\_\_\_\_

Brian G. Brannman  
Chief Executive Officer

**Attachment “A”**

**UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA  
ADMINISTRATIVE POLICY AND PROCEDURE MANUAL**

|  |  |                          |
|--|--|--------------------------|
| SUBJECT: Contracted Non Employees / Allied Health Non Credentialed / Dependent Allied Health / Temporary Staff / Third Party Equipment |  | ADMINISTRATIVE APPROVAL: |
| EFFECTIVE: 9/96  | REVISED: <b>6/11</b> ; 1/08; 4/07; 10/01; 6/99 |                          |
| POLICY #: I-66   |  |                          |
| AFFECTS: Organization wide   |  |                          |

**PURPOSE:**

To assure that contractual agreements for the provision of services are consistent with the level of care defined by Hospital policy; and, to ensure the priority utilization of contracted services, staffing and equipment.

**POLICY:**

1. All entities providing UMC with personnel for temporary staffing and Allied Health Providers must have a written contract that contains the terms and conditions required by this policy. Dependent Allied providers working with credentialed physicians without a contract must also abide by the policy.
2. All Credentialed Physicians, Physician Assistants, Nurse Practitioners and other credentialed Allied Health personnel will abide by the policies and procedures as set by the Medical Staff Bylaws.
3. All equipment provided and used by outside entities must meet the safety requirements required by this policy.
4. Contract(s) will be developed collaboratively by the department(s) directly impacted, the service agency and the hospital Contracts Management Department.
5. Contract(s) directly related to patient care must be reviewed and evaluated by the Medical Executive Committee to ensure clinical competency.
6. Contract(s) must be approved by the Chief Executive Officer or applicable board prior to the commencement of services.

**TEMPORARY STAFFING:**

**Contractual Requirements**

Contractor must meet and adhere to all qualifications and standards established by Hospital policies and procedures; The Joint Commission; and, all applicable regulatory and/or credentialing entities specific to services included in contract.

In the event a contractor contracts with an individual who is certified under the aegis of the Medical and Dental Staff Bylaws or Allied Health, the contract must provide contracted individuals applicable education, training, and licensure be appropriate for the assigned responsibilities. The contracted individual must fulfill orientation requirements consistent with other non-employee staff members.

Records concerning the contracted individual shall be maintained by Hospital's Department of Human Resources (HR) and the clinical department directly impacted by the services provided. HR will provide Employee Health and Employee Education information with an on-going list of these individuals and the department in which they work.

### **Laboratory Services**

All reference and contracted laboratory services must meet the applicable federal regulations for clinical laboratories and maintain evidence of the same.

### **Healthcare Providers**

In the event a service agency employs or contracts with an individual who is subject to the Medical and Dental Staff Bylaws, or the Allied Health Providers Manual, the contract must provide individual's applicable education, training, and licensure appropriate for his or her assigned responsibilities. The assigned individual must have an appropriate National Provider Identifier (NPI).

### **Clinical Care Services**

Contractor may employ such Allied Health providers as it determines necessary to perform its obligations under the contract. For each such Allied Health provider, contractor shall be responsible for furnishing Hospital with evidence of the following:

1. Written job description that indicates:
  - a. Required education and training consistent with applicable legal and regulatory requirements and Hospital policy.
  - b. Required licensure, certification, or registration as applicable.
  - c. Required knowledge and/or experience appropriate to perform the defined scope of practice, services, and responsibilities.
2. Completed pre-employment drug screen and background check consistent with UMC's contracted background check protocol. Testing should include HHS Office of Inspector General (OIG), Excluded party list system (EPLS), sanction checks and criminal background. If a felony conviction exists, UMC's HR department will review and approve or deny the Allied Health Practitioner's access to UMC Campus. UMC will be given authorization to verify results online by contractor.
3. Physical examination or certification from a licensed physician stating good health.
4. Current (within the last 12 months) negative TB skin test or blood test, or for past positive individual's a sign and symptom review and Chest X-ray if any documented positive signs and symptoms.
5. For individuals exposed to Blood and body fluids; Hepatitis B series, a titer showing immunity or a signed declination statement if vaccine refused. UMC will provide form for declination as needed.
6. A history of chicken pox, a titer showing immunity, or proof of 2 varivax vaccinations.
7. Measles, mumps and rubella titers showing immunity, or proof of 2 MMR vaccines

8. Current Influenza and Tdap vaccine. Influenza vaccine required between October 1st and March 31<sup>st</sup>. Any staff with a medical reason for refusing a vaccination must sign declination.
9. Ensure these records are maintained and kept current at the agency and be made available upon request. Contractor will provide authorization to University Medical Center to audit these files upon request. Measles/Mumps/Rubella Immunizations or adequate titers. Chicken Pox status must be established by either a history of chicken pox, a serology showing positive antibodies or proof of varivax and other required testing. Ensure these records are maintained and kept current at the agency and be made available upon request. Contractor will provide UMC authorization to audit these files upon request.
10. The contractor will complete a competency assessment of the individual (1) upon hire, (2) at the time initial service is provided, (3) when there is a change in either job performance or job requirements, and (4) on an annual basis.
  - a. Competency assessments of allied health providers must clearly establish that the individual meets all qualifications and standards established by Hospital policies and procedures, The Joint Commission, and all other applicable regulatory and/or credentialing entities with specific application to the service provided.
  - b. Competency assessments of allied health providers must clearly address the ages of the patients served by the individual and the degree of success the individual achieves in producing the results expected from clinical interventions.
  - c. Competency assessments must include an objective, measurable system, and be used periodically to evaluate job performance, current competencies, and skills.
  - d. Competency assessments must be performed annually, allow for Hospital input and be submitted to Hospital's Department of HR.
  - e. The competency assessment will include a competency checklist for each allied health provider position, which at a minimum addresses the individual's:
    - i. Knowledge and ability required to perform the written job description;
    - ii. Ability to effectively and safely use equipment;
    - iii. Knowledge of infection control procedures;
    - iv. Knowledge of patient age-specific needs;
    - v. Knowledge of safety procedures; and
    - vi. Knowledge of emergency procedures.
11. Contractor has conducted an orientation process to familiarize allied health providers with their jobs and with their work environment before beginning patient care or other activities at UMC inclusive of safety and infection control. The orientation process must also assess each individual's ability to fulfill the specific job responsibilities set forth in the written job description.
12. Contractor periodically reviews the individual's abilities to carry out job responsibilities, especially when introducing new procedures, techniques, technology, and/or equipment.

13. Contractor has developed and furnishes ongoing in-service and other education and training programs appropriate to patient age groups served by Hospital and defined within the scope of services.
14. Contractor submits to Hospital for annual review:
  - a. The level of competence of the contractor's allied health providers that meets UMC standards; and
  - b. The patterns and trends relating to the contractor's use of allied health providers.
15. Contractor ensures that each allied health provider has acquired an identification badge from Hospital's Department of Human Resources before commencing services at Hospital's facilities; and, ensures badge is returned to HR upon termination of service.
16. Contract requires the contractor, upon Hospital's request, to discontinue the employment at Hospital's facilities of an allied health provider whose performance is unsatisfactory, whose personal characteristics prevent desirable relationships with Hospital staff, whose conduct may have a detrimental effect on patients, or who fails to adhere to Hospital's existing policies and procedures. The supervising department will complete an exit review form and submit to HR for individual's personnel file.

**Non Clinical Short Term Temporary Personnel**

Non clinical short term personnel on site for construction, remodeling or new project implementation purposes will abide by Hospital's I-179 Vendor Roles and Responsibilities and/or Engineering Department processes. This process is applicable to anyone that is on property ninety (90) days or less.

**EQUIPMENT:**

In the event Hospital contracts for equipment services, documentation of a current, accurate and separate inventory equipment list must be provided to HR to be included in Hospital's medical equipment management program.

1. All equipment brought into UMC is required to meet the following criteria:
  - a. Electrical safety check which meets the requirements of Hospital's Clinical Engineering Department.
  - b. Established schedule for ongoing monitoring and evaluation of equipment submitted to Hospital's Clinical Engineering Department.
  - c. Monitoring and evaluation will include:
    - i. Preventive maintenance;
    - ii. Identification and recordation of equipment management problems;
    - iii. Identification and recordation of equipment failures; and
    - iv. Identification and recordation of user errors and abuse.
  - d. Results of monitoring and evaluation shall be recorded as performed and submitted to Hospital's Department of Clinical Engineering.



2. Documentation on each contractor providing medical equipment to assure users of equipment are able to demonstrate or describe:
  - a. Capabilities, limitations, and special applications of the equipment;
  - b. Operating and safety procedures for equipment use;
  - c. Emergency procedures in the event of equipment failure; and
  - d. Processes for reporting equipment management problems, failures and user errors.
3. Documentation on each contractor providing medical equipment to assure technicians maintaining and/or repairing the equipment can demonstrate or describe:
  - a. Knowledge and skills necessary to perform maintenance responsibilities; and
  - b. Processes for reporting equipment management problems, failures and user errors.

**MONITORING:**

The contractor will provide reports of performance improvement activities at defined intervals.

A contractor providing direct patient care will collaborate, as applicable, with Hospital's Performance Improvement Department regarding Improvement Organization Performance (IOP) activities.

**Process for Allied Health Provider working at UMC Hospital Campus**

1. All Allied Health and Dependent Allied Health Provider personnel from outside contractors monitored by HR (non-credentialed/licensed) working at UMC will have the following documentation on file in Department of Human Resources:
  - a. Copy of contract
  - b. Copy of Contractor's liability insurance (general and professional)
  - c. Job description
  - d. Resume
  - e. Copy of current Driver's License **OR** One 2x2 photo taken within 2 years
  - f. Specialty certifications, Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS), etc.
  - g. Current license verification/primary source verifications
  - h. Competency Statement/Skills Checklist (Contractor's and UMC's)
  - i. Annual Performance Evaluation(s)
  - j. UMC Department Specific Orientation

- k. Attestation form/letter from Contractor completed for medical clearances
- l. Completion of Non-Employee specific orientation
2. The following documents may be maintained at Contractor's Office:
  - a. Medical Information to include: History and Physical (H&P), Physical examination or certification from a licensed physician that a person is in a state of good health, (Clinical Personnel) Annual Tuberculosis (TB)/health clearance test or Chest X-Ray, Immunizations, Hepatitis B Series or waiver, Measles/Mumps/Rubella Immunizations or adequate titers, Chicken Pox questionnaire, Drug tests results and other pertinent health clearance records as required. The results of these tests can be noted on a one (1) page medical attestation form provided by UMC.
  - b. Attestation form must be signed by the employee and contractor. The form can be utilized to update information as renewals or new tests. The form must be provided to Hospital each time a new employee is assigned to UMC. Once the above criteria are met, the individual will be scheduled to attend orientation, receive an identification badge, and IT security access.
  - c. Any and all peer references and other clearance verification paperwork must be maintained in the contractor's office and be available upon request.

**Non-Employee Orientation – Provided by the Employee Education Department**

1. Non-Employee orientation must occur prior to any utilization of contracted personnel.
2. Orientation may be accomplished by attendance at non-employee orientation; or, by completion of the "Agency Orientation Manual" if scheduled by the Education Department.
3. Nurses must complete the RN orientation manual before working if Per Diem and within one week of hire if a traveler. RN orientation will be scheduled by the appropriate responsible UMC Manager.
4. Each contracted personnel will have a unit orientation upon presenting to a new area. This must be documented and sent to Employee Education. Components such as the PYXIS tutorial and competency, Patient Safety Net (PSN), Information Technology Services (IT), Glucose monitoring as appropriate and any other elements specific to the position or department.

**Contractor Personnel Performance Guidelines**

1. Arrive at assigned duty station at the start of shift. Tardiness will be documented on evaluation.
2. Complete UMC incident reports and/or medication error reports when appropriate using the PSN. The Contractual individual is to report to the Director of their employer all incidents and medication errors for which they are responsible. UMC will not assume this responsibility. UMC agrees to notify Agency when an employee(s) is known to have been exposed to any communicable diseases.

**Agency Personnel Assignment Guidelines**

1. Duties will be assigned by the Physicians, Department Manager, Charge Nurse/Supervisor that matches their skill level as defined on the competency checklist.
2. Administer care utilizing the standards of care established and accepted by UMC.

3. Be responsible to initiate update or give input to the plan of care on their assigned patients as defined in job description.
4. Will not obtain blood from the lab unless properly trained by the unit/department to do so. Training must be documented and sent to Employee Education department.
5. Administer narcotics as appropriate to position and scope of practice.

## **Attachment “B”**

### **Notice of False Claims and Statements**

UMC’s Compliance Program demonstrates its commitment to ethical and legal business practices and ensures service of the highest level of integrity and concern. UMC’s Compliance Department provides UMC compliance oversight, education, reporting and resolution. It conducts routine, independent audits of UMC’s business practices and undertakes regular compliance efforts relating to, among other things, proper billing and coding, detection and correction of coding and billing errors, and investigation of and remedial action relating to potential noncompliance. It is our expectation that as a physician, business associate, contractor, vendor, or agent, your business practices are committed to the same ethical and legal standards.

The purpose of this Notice is to educate you regarding the federal and state false claims statutes and the role of such laws in preventing and detecting fraud, waste, and abuse in federally funded health care programs. As a Medical Staff Member, Vendor, Contractor and/or Agent, you and your employees must abide by UMC’s policies insofar as they are relevant and applicable to your interaction with UMC. Additionally, providers found in violation of any regulations regarding false claims or fraudulent acts are subject to exclusion, suspension, or termination of their provider status for participation in Medicaid.

#### *Federal False Claims Act*

The Federal False Claims Act (the “Act”) applies to persons or entities that knowingly and willfully submits, cause to be submitted, conspire to submit a false or fraudulent claim, or use a false record or statement in support of a claim for payment to a federally-funded program. The Act applies to all claims submitted by a healthcare provider to a federally funded healthcare program, such as Medicare.

Liability under the Act attaches to any person or organization who “knowingly”:

- Present a false/fraudulent claim for payment/approval;
- Makes or uses a false record or statement to get a false/fraudulent claim paid or approved by the government;
- Conspires to defraud the government by getting a false/fraudulent claim paid/allowed;
- Provides less property or equipment than claimed; or
- Makes or uses a false record to conceal/decrease an obligation to pay/provide money/property.

“Knowingly” means a person has: 1) actual knowledge the information is false; 2) acts in deliberate ignorance of the truth or falsity of the information; or 3) acts in reckless disregard of the truth or falsity of the information. No proof of intent to defraud is required.

A “claim” includes any request/demand (whether or not under a contract), for money/property if the US Government provides/reimburses any portion of the money/property being requested or demanded.

For knowing violations, civil penalties range from \$5,500 to \$11,000 in fines, per claim, plus three times the value of the claim and the costs of any civil action brought. If a provider unknowingly accepts payment in excess of the amount entitled to, the provider must repay the excess amount.

Criminal penalties are imprisonment for a maximum 5 years; a maximum fine of \$25,000; or both.

#### *Nevada State False Claims Act*

Nevada has a state version of the False Claims Act that mirrors many of the federal provisions. A person is liable under state law, if they, with or without specific intent to defraud, “knowingly.”

- presents or causes to be presented a false claim for payment or approval;
- makes or uses, or causes to be made or used, a false record/statement to obtain payment/approval of a false claim;
- conspires to defraud by obtaining allowance or payment of a false claim;

- has possession, custody or control of public property or money and knowingly delivers or causes to be delivered to the State or a political subdivision less money or property than the amount for which he receives a receipt;
- is authorized to prepare or deliver a receipt for money/property to be used by the State/political subdivision and knowingly prepares or delivers a receipt that falsely represents the money/property;
- buys or receives as security for an obligation, public property from a person who is not authorized to sell or pledge the property; or
- makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the state/political subdivision.

Under state law, a person may also be liable if they are a beneficiary of an inadvertent submission of a false claim to the state, subsequently discovers that the claim is false, and fails to disclose the false claim to the state within a reasonable time after discovery of the false claim.

Civil penalties range from \$5,000 to \$10,000 for each act, plus three times the amount of damages sustained by the State/political subdivision and the costs of a civil action brought to recover those damages.

Criminal penalties where the value of the false claim(s) is less than \$250, are 6 months to 1 year imprisonment in the county jail; a maximum fine of \$1,000 to \$2,000; or both. If the value of the false claim(s) is greater than \$250, the penalty is imprisonment in the state prison from 1 to 4 years and a maximum fine of \$5,000.

#### *Non-Retaliation/Whistleblower Protections*

Both the federal and state false claims statutes protect employees from retaliation or discrimination in the terms and conditions of their employment based on lawful acts done in furtherance of an action under the Act. UMC policy strictly prohibits retaliation, in any form, against any person making a report, complaint, inquiry, or participating in an investigation in good faith.

An employer is prohibited from discharging, demoting, suspending, harassing, threatening, or otherwise discriminating against an employee for reporting on a false claim or statement or for providing testimony or evidence in a civil action pertaining to a false claim or statement. Any employer found in violation of these protections will be liable to the employee for all relief necessary to correct the wrong, including, if needed,:

- reinstatement with the same seniority; or
- damages in lieu of reinstatement, if appropriate; and
- two times the lost compensation, plus interest; and
- any special damage sustained; and
- punitive damages, if appropriate.

#### *Reporting Concerns Regarding Fraud, Abuse and False Claims*

Anyone who suspects a violation of federal or state false claims provisions is required to notify UMC via a hospital Administrator, department Director, department Manager, or Angela Darragh, the Corporate Compliance Officer, directly at (702) 383-6211. Suspected violations may also be reported anonymously via the Hotline at (888) 691-0772 or <http://umcsn.silentwhistle.com>. The Hotline is available 24 hours a day, seven days a week. Compliance concerns may also be submitted via email to the Compliance Officer at [compliance.officer@umcsn.com](mailto:compliance.officer@umcsn.com).

Upon notification, the Compliance Officer will initiate a false claims investigation. A false claims investigation is an inquiry conducted for the purpose of determining whether a person is, or has been, engaged in any violation of a false claim law.

Retaliation for reporting, in good faith, actual or potential violations or problems, or for cooperating in an investigation is expressly prohibited by UMC policy.

## **Exhibit “C”**

### **SCOPE OF PROJECT**

#### **IV. Provider and Principal Physician – General Requirements**

1. Principal Physician must hold at all times a current license as a neurosurgeon from the American Board of Neurological Surgery. The Principal Physician’s back up physician must also be board certified or eligible in Neurological Surgery.
2. No Member Physician may be an “Excluded Provider” from any federally funded healthcare program.
3. All Member Physicians must be licensed to practice medicine within the State of Nevada. All licenses must be unrestricted and in good standing.
4. The Principal Physician shall act as the liaison with Hospital and its Medical Staff to resolve patient care issues.

#### **V. Provider Staffing**

1. All staff must obtain medical staff privileges at University Medical Center of Southern Nevada
2. All staff must carry malpractice insurance coverage at their own expense in accordance with the minimums established by the Bylaws, Rules and Regulations of the Medical and Dental Staff. Said insurance shall annually be certified to Hospital’s Administrator and Medical Staff, as necessary.
3. All staff must be eligible to be credentialed by and contract with various managed care plans with which Owner has a contract.
4. All staff must agree to follow all University Medical Center policies and the Bylaws, Rules and Regulations of the Medical Staff.
5. All staff must also meet all legal and licensing requirements set forth by the State of Nevada and Clark County.

#### **VI. Duties – General**

1. Provider shall provide professional services in the best interests of Hospital’s patients with all due diligence.
2. Provider will provide Services so that a Physician is present when required for delivery of Services to Patients. Provider shall consult with the Medical Staff of Hospital when requested.

3. Except as otherwise provided in subsection 4 below, Provider shall provide Hospital with consultative coverage in accordance with the Bylaws, Rules and Regulations of the Medical and Dental Staff. For this purpose consultative coverage consists of patient examination/assessment, diagnosis, medical/surgical intervention and follow-up care. This coverage includes all Hospital inpatients, Hospital outpatients, Emergency Department patients and Trauma Department patients who are not designated patients of other physicians unless resident coverage has been assigned to another group or physician on a predetermined and agreed upon scheduled rotation.
4. Provider shall provide service on an emergency and on-call basis to meet the needs of Hospital's inpatients and outpatients.
5. Provider shall coordinate the schedules and assignments of the physicians assigned to Services. At no time will Services be without coverage.
6. Provider shall encourage the participation of other physicians in the community to assist Provider in the provision of the services outlined in this Agreement.

#### IV. Duties – Teaching

Provide for the education of Medical Staff and Hospital personnel, residents and medical students in a defined organized structure and as the need presents itself.

#### V. Managed Care Organizations

All Member Physicians must be eligible to be credentialed by and contract with various managed care plans with which Hospital has a contract.

#### VI. Billing

Successful Provider shall directly bill patients and/or third party payors for all professional components. Hospital shall provide, at Hospital's expense, usual social security and insurance information to facilitate direct billing. Hospital is not responsible for the billing or collection of professional components.

#### VII. Independent Contractor

The successful Provider represents that it is fully experienced and properly qualified to perform the class of work provided for herein, that it is properly licensed, equipped, organized and financed to fulfill all requirements. The successful Provider shall act as an independent contractor and not as the agent of Hospital in performing the contract. The successful Provider/Respondent shall maintain complete control over its employees and shall perform all work in accordance with its own methods subject to compliance with the Contract.

## **Attachment “D”**

### **Standards of Performance**

#### **I. Standards of Performance.**

- a. Provider shall to adhere to Hospital's established standards and policies for providing good patient care. In addition, Provider shall ensure that its Member Physicians shall also operate and conduct themselves in accordance with the standards and recommendations of The Joint Commission, all applicable national patient safety goals, and the Bylaws, Rules and Regulations of the Medical and Dental Staff, as may then be in effect.
- b. Hospital expressly agrees that the professional services of Provider may be performed by such physicians as Provider may associate with, so long as Provider has obtained the prior written approval of Hospital. So long as Provider is performing the services required hereby, its employed or contracted physicians shall be free to perform private practice at other offices and hospitals. If any of Provider's Member Physicians are employed by Provider under the J-1 Visa waiver program, Provider will so advise Hospital, and Provider shall be in strict compliance, at all times during the performance of this Agreement, with all federal laws and regulations governing said program and any applicable state guidelines.
- c. Provider shall maintain professional demeanor and not violate Medical Staff Physician's Code of Conduct.
- d. Provider shall develop and implement guidelines and critical pathways to improve quality of care and decrease length of stay.
- e. Provider shall cause Member Physicians to perform Services at all times in accordance with current medical standards of practice for neurosurgery services.
- f. Provider shall meet all applicable standards of The Joint Commission and CMS.
- g. Provider shall maintain at a minimum ninety-five percent (95%) compliance with all quality standards including applicable core measures to include:
  - i. SCIP Infection-9 Postoperative urinary catheter removal on post operative day 1 or 2; and,
- h. Provider shall maintain the fiftieth (50<sup>th</sup>) percentile for all scores of the HCAHPS surveys applicable to Provider.
- i. Providers shall be 95% complaint with all SCIP Initiatives,
  - a. Provider shall ensure that all medical records will be completed and signed within thirty (30) days of treatment and all verbal orders will be signed within forty-eight (48) hours.



- j. Provider shall collaborate with Hospital leadership to minimize and address staff and patient complaints. Provider shall participate with Hospital's Administration in staff evaluations and joint operating committees.
- k. Provider shall meet quarterly with Hospital Administration to discuss and verify inpatient admission data collections.
- l. Provider shall cause Member Physicians to implement and adhere to the overall criteria for continuous quality improvement as outlined and adopted by Hospital pursuant to the guidelines of the The Joint Commission and the American College of Physicians.
- m. Physicians shall attend at least 50 percent (50%) of the Physician Preference and/or Value Analysis meetings per calendar year.
- n. Provider shall conduct legible pre-op and post-op assessments.
- o. Provider shall maintain communication as set forth in the Bylaws, Rules and Regulations of the Medical and Dental Staff.
- p. Provider shall ensure that all the elements of the Surgical Safety Checklist, including appropriate pre-op evaluation, adherence to all SCIP metrics including complete" time-out", "appropriate" antibiotic timing in the OR, completion of a thorough post-operative note, etc. are utilized 100% of the time.

## Attachment "E"

### DELINEATION OF TRAUMA NEUROSURGERY PRIVILEGES

UNIVERSITY MEDICAL CENTER - LAS VEGAS, NEVADA

DEPARTMENT OF TRAUMA

#### DELINEATION OF TRAUMA NEUROSURGERY PRIVILEGES

NAME: \_\_\_\_\_ Initial Application \_\_\_\_\_  
Renewed \_\_\_\_\_

Effective From: \_\_\_\_/\_\_\_\_/\_\_\_\_ TO \_\_\_\_/\_\_\_\_/\_\_\_\_

The establishment of privileges and procedures in the Department of Trauma shall be in accordance with the Bylaws of the Medical and Dental staff. Neurosurgeons in the Department of Trauma have privileges to admit, and treat pregnant or non-pregnant, adult and pediatric patients who meet triage criteria and to participate in the management and treatment of these critically ill patients.

**Eligibility Criteria:** To be eligible to request **CORE** clinical privileges, the applicant must be a current member in good standing of the Medical and Dental staff, the Department of Neurosurgery, and meet the following minimum criteria:

**Basic Education:** M.D. or D.O.

**Minimal Formal Training:**

- Successful completion of an accredited ACGME or AOA residency training program in Neurosurgery.
- Board certified by the American Board of Neurosurgery (as certified by the American Board of Medical Specialists) or equivalent by the American Osteopathic Association; and the Royal College of Physicians and Surgeons of Canada. Board eligible as defined by completion of certification process within five (5) years of postgraduate training.
- Must possess qualifications pursuant to established ACS guidelines as outlined in the current "Resources for Optimal Care of the Injured Patient".

**Experience:**

- Physician must be a Neurosurgeon as demonstrated by current practice experience in the broad range of neurosurgery, and who is well qualified in the management of neurologically injured patients.
- Certification of Advanced Trauma Life Support at the Provider Level strongly recommended.
- Sixteen (16) hours of verifiable external Trauma Related Continuing Medical Education per year
- Knowledge of Trauma Team physician roles and Department policies.

**Compliance Standards:**

- Response time shall be in five (5) minutes call back by telephone when paged. In person response is required within twenty (20) minutes when requested by Attending Trauma Surgeon.
- A 75% attendance threshold must be met for the following meetings:
  1. Monthly Multidisciplinary Peer Review Meeting
  2. Monthly Trauma Department Meeting
  3. Weekly Peer Review strongly encouraged.
- The Trauma Neurosurgeon must participate in the principles and practices of Peer Review and Performance Improvement. Performance Improvement participation includes literature review, application of evidence based standards and honest discussion of best practices. Performance Improvement and Peer Review activities can be case specific and/or aggregate trended data.

Individuals who are unwilling or unable to complete remediation may have their privileges restricted pursuant to Article IV of the Rules and Regulations of the Department of Trauma.

- Must supervise and teach Medical Students and Residents on the Trauma Service.
- Must develop and follow established practice guidelines for systematic evaluations and management of common injuries.

**History & Physical:** Competent to perform patient's medical history & physical examination.

| <b>CORE PRIVILEGES IN TRAUMA NEUROSURGERY</b>  |                             |                     |                    |                                |
|--|-----------------------------|---------------------|--------------------|--------------------------------|
| <b>PRIVILEGE</b>   | <b>SPECIAL REQUIREMENTS</b> | <b>R= REQUESTED</b> | <b>A= APPROVED</b> | <b>C=APPROVED W/CONDITIONS</b> |
| <p><b>CORE</b> privileges in Trauma Neurosurgery include the performance of neurosurgical procedures, including admission, consultation, workup, peri-operative care to correct and treat conditions, illness or traumatic injuries in pregnant or non-pregnant adult and pediatric patients who meet triage criteria. Also included within these <b>CORE</b> privileges is the comprehensive management of neuro-trauma including cranial, spinal and peripheral nerve injuries throughout the continuum of trauma care. A representative, but of necessity, not complete list of procedures is listed below.</p> <p><b>Central Nervous System</b><br/>Intracranial Pressure Monitoring (ICP); Craniotomy/craniectomy; Insertion of Ventricular Shunts; Management and repair of tissue defects of the scalp and skull; Treatment and management of spinal cord injuries including surgical decompression and spinal instrumentation</p> <p><b>Spine, skeletal</b><br/>Application of external fixation devices (Halo, Gardner-Wells tongs)</p> <p><b>Peripheral Nervous System</b><br/>Repair and revision of peripheral nerve injuries</p> <p><b>Interpretation of Diagnostic Studies</b><br/>Percutaneous Cerebral Angiography; Spinal radiographs; CT scan; MRI; Cerebral Blood Flow Studies; Electroencephalography; Evoked Potentials</p> |                             |                     |                    |                                |

#### **SPECIAL PRIVILEGES IN TRAUMA NEUROSURGERY**

**SPECIAL** privileges are defined as high risk, problem prone or new technology and not routinely part of general neurosurgery practice.

**Eligibility Criteria:** To be eligible to request **SPECIAL** privileges, the applicant must meet the minimum criteria for **CORE** privileges in addition to the following:

Minimal Formal Training: Successful completion of an accredited ACGME or AOA residency training program in neurosurgery. Board certified by the American Board of Neurosurgery (as certified by the American Board of Medical Specialists) or equivalent by the American Osteopathic Association; and the Royal College of Physicians and Surgeons of Canada. Board eligible as defined by completion of certification process within five (5) years of postgraduate training. Demonstration of knowledge of indications for the procedure/test/ therapy, PLUS

**Previous Experience:**

Documentation of successful completion of training and demonstrated current competence in the privilege(s) requested, and Documentation of competence to obtain and retain clinical privileges as set forth in departmental rules and regulations governing the exercise of specific privileges.

| <b>SPECIAL PRIVILEGES IN TRAUMA NEUROSURGERY</b>                          |                             |                     |                    |                                |
|---|-----------------------------|---------------------|--------------------|--------------------------------|
| <b>PRIVILEGE</b>  | <b>SPECIAL REQUIREMENTS</b> | <b>R= REQUESTED</b> | <b>A= APPROVED</b> | <b>C=APPROVED W/CONDITIONS</b> |
| <b>Intracranial Pressure Monitoring via Carotid Blood Flow Monitoring</b> |                             |                     |                    |                                |
| <b>Use of Laser for neurosurgical therapy</b>                             |                             |                     |                    |                                |
| <b>Moderate Sedation (by Hospital Protocol)</b>                           |                             |                     |                    |                                |
| <b>Deep Sedation (by Hospital Protocol)</b>                               |                             |                     |                    |                                |

**ACKNOWLEDGEMENT OF PRACTITIONER**

I have requested only those privileges for which by education, training, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise at University Medical Center of Southern Nevada, in the Department of Trauma and, I understand that

- In exercising any clinical privileges granted, I am constrained by Hospital and Medical staff policies and rules applicable generally and any applicable to the particular situation.
- Any restrictions on the clinical privileges granted to me are waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws.

I have attached the supporting documentation required to request these Neurosurgery Trauma **CORE** and **SPECIAL** privileges.

\_\_\_\_\_  
APPLICANT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
CHIEF, DEPARTMENT OF NEUROSURGERY

\_\_\_\_\_  
DATE

\_\_\_\_\_  
CHIEF, DEPARTMENT OF TRAUMA

\_\_\_\_\_  
DATE

Department of Trauma, University Medical Center

Revised: 5/99, 12/03, 01/07; 06/09

Approved: Board of Trustees 4/20/99; 03/05, 05/07; 10/09

## Attachment “F”

### Deliverables

#### I. Deliverables

|   | <b>Deliverable</b>  | <b>Due to UMC Contracts Management</b>                              | <b>Submitted To</b>            |
|---|---|---|--------------------------------|
| 1 | Submit Industrial and Professional Liability Insurance Certificates annual  | Annual on contract anniversary date                                 | Contracts Management           |
| 2 | Submit Report that includes: <ul style="list-style-type: none"><li>- Number of patients consulted</li><li>- Number of calls responded to</li><li>- Number of patients treated</li><li>- Breakdown of patient payor sources</li><li>- Percentage of amount paid compared to billed</li></ul> | Quarterly   | COO, CMO, Contracts Management |
| 3 | Copies of Medical Provider associate agreements and their CV  | As required   | Contracts Management           |
| 4 | Call Schedule with the following information <ul style="list-style-type: none"><li>- Date of service period</li><li>- Primary Contact Name, Cell Phone, Pager Number</li><li>- Back-up Contact Name, Cell Phone, Pager Number</li></ul>   | Submitted by 29 <sup>th</sup> of each month for the following month | COO, CMO                       |
| 5 | Meeting attendance  | As Required   | N/A                            |
| 6 | Listing of all members within the Primary Physicians group. Reports shall contain at least the following: Physician Name, license number, specialty.  | Quarterly   | Physician Credentialing        |

**EXHIBIT G**

**INSURANCE REQUIREMENTS**

**TO ENSURE COMPLIANCE WITH THE CONTRACT DOCUMENT, PROPOSER SHOULD FORWARD THE FOLLOWING INSURANCE CLAUSE AND SAMPLE INSURANCE FORM TO THEIR INSURANCE AGENT PRIOR TO PROPOSAL SUBMITTAL.**

1. Format/Time: The PROPOSER shall provide Owner with Certificates of Insurance, per the sample format (page B-3), for coverages as listed below, and endorsements affecting coverage required by this Contract within **10 calendar days** after the award by the Owner. All policy certificates and endorsements shall be signed by a person authorized by that insurer and who is licensed by the State of Nevada in accordance with NRS 680A.300. All required aggregate limits shall be disclosed and amounts entered on the Certificate of Insurance, and shall be maintained for the duration of the Contract and any renewal periods.
2. Best Key Rating: The Owner requires insurance carriers to maintain during the contract term, a Best Key Rating of A.VII or higher, which shall be fully disclosed and entered on the Certificate of Insurance.
3. Owner Coverage: The Owner, its officers and employees must be expressly covered as additional insureds except on workers' compensation and professional liability insurance coverages. The PROPOSER's insurance shall be primary as respects the Owner, its officers and employees.
4. Endorsement/Cancellation: The PROPOSER's general liability insurance policy shall be endorsed to recognize specifically the PROPOSER's contractual obligation of additional insured to Owner and must note that the Owner will be given thirty (30) calendar days advance notice by certified mail "return receipt requested" of any policy changes, cancellations, or any erosion of insurance limits.
5. Deductibles: All deductibles and self-insured retentions shall be fully disclosed in the Certificates of Insurance and may not exceed \$25,000.
6. Aggregate Limits: If aggregate limits are imposed on bodily injury and property damage, then the amount of such limits must not be less than \$2,000,000.
7. Commercial General Liability: Subject to paragraph 6 of this Exhibit, the PROPOSER shall maintain limits of no less than \$1,000,000 combined single limit per occurrence for bodily injury (including death), personal injury and property damages. Commercial general liability coverage shall be on a "per occurrence" basis only, not "claims made," and be provided either on a Commercial General Liability or a Broad Form Comprehensive General Liability (including a Broad Form CGL endorsement) insurance form.
8. Automobile Liability: Subject to paragraph 6 of this Exhibit, the PROPOSER shall maintain limits of no less than \$1,000,000 combined single limit per occurrence for bodily injury and property damage to include, but not be limited to, coverage against all insurance claims for injuries to persons or damages to property which may arise from services rendered by PROPOSER and any auto used for the performance of services under this Contract.
9. Professional Liability: The PROPOSER shall maintain limits of no less than \$1,000,000 aggregate. If the professional liability insurance provided is on a Claims Made Form, then the insurance coverage required must continue for a period of 2 years beyond the completion or termination of this Contract. Any retroactive date must coincide with or predate the beginning of this and may not be advanced without the consent of the Owner.
10. Workers' Compensation: The PROPOSER shall obtain and maintain for the duration of this contract, a work certificate and/or a certificate issued by an insurer qualified to underwrite workers' compensation insurance in the State of Nevada, in accordance with Nevada Revised Statutes Chapters 616A-616D, inclusive, provided, however, a PROPOSER that is a Sole Proprietor shall be required to submit an affidavit (Exhibit D) indicating that the PROPOSER has elected not to be included in the terms, conditions and provisions of Chapters 616A-616D, inclusive, and is otherwise in compliance with those terms, conditions and provisions.
11. Failure To Maintain Coverage: If the PROPOSER fails to maintain any of the insurance coverages required herein, Owner may withhold payment, order the PROPOSER to stop the work, declare the PROPOSER in breach, suspend or terminate the Contract, assess liquidated damages as defined herein, or may purchase replacement insurance or pay premiums due on existing policies. Owner may collect any replacement insurance costs or premium payments made from the PROPOSER or deduct the amount paid from any sums due the PROPOSER under this Contract.
12. Additional Insurance: The PROPOSER is encouraged to purchase any such additional insurance as it deems necessary.
13. Damages: The PROPOSER is required to remedy all injuries to persons and damage or loss to any property of Owner, caused in whole or in part by the PROPOSER, their subcontractors or anyone employed, directed or supervised by PROPOSER.

14. Cost: The PROPOSER shall pay all associated costs for the specified insurance. The cost shall be included in the price(s).
15. Insurance Submittal Address: All Insurance Certificates requested shall be sent to the Clark County Purchasing and Contracts Division, Attention: Insurance Coordinator. See the Submittal Requirements Clause in the RFP package for the appropriate mailing address.
16. Insurance Form Instructions: The following information must be filled in by the PROPOSER's Insurance Company representative:
- 1) Insurance Broker's name, complete address, phone and fax numbers.
  - 2) PROPOSER's name, complete address, phone and fax numbers.
  - 3) Insurance Company's Best Key Rating
  - 4) Commercial General Liability (Per Occurrence)
    - (A) Policy Number
    - (B) Policy Effective Date
    - (C) Policy Expiration Date
    - (D) General Aggregate (\$2,000,000)
    - (E) Products-Completed Operations Aggregate (\$2,000,000)
    - (F) Personal & Advertising Injury (\$1,000,000)
    - (G) Each Occurrence (\$1,000,000)
    - (H) Fire Damage (\$50,000)
    - (I) Medical Expenses (\$5,000)
  - 5) Automobile Liability (Any Auto)
    - (J) Policy Number
    - (K) Policy Effective Date
    - (L) Policy Expiration Date
    - (M) Combined Single Limit (\$1,000,000)
  - 6) Worker's Compensation
  - 7) Description: RFP Number and Name of Contract (must be identified on the initial insurance form and each renewal form).
  - 8) Certificate Holder:

University Medical Center of Southern Nevada  
1800 West Charleston Boulevard  
Las Vegas, Nevada 89102

**THE CERTIFICATE HOLDER, UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA, MUST BE NAMED AS AN ADDITIONAL INSURED.**

- 9) Appointed Agent Signature to include license number and issuing state.

# CERTIFICATE OF INSURANCE

ISSUED DAY (MM/DD/YY)

## PRODUCER

1. **INSURANCE BROKER'S NAME, ADDRESS, CONTACT NAME, PHONE & FAX NUMBERS**

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

COMPANIES AFFORDING COVERAGE

3. BEST'S RATING

COMPANY A  
LETTER

COMPANY'S

## INSURED

2. **SUCCESSFUL BIDDER'S NAME, ADDRESS, PHONE & FAX NUMBERS**

COMPANY B  
LETTER

BEST KEY

COMPANY C  
LETTER

RATING

COMPANY D  
LETTER

COMPANY E  
LETTER

## COVERAGES

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED, NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

| CO LTR | TYPE OF INSURANCE   | POLICY NUMBER | POLICY EFFECTIVE DATE (MM/DD/YY) | POLICY EXPIRATION DATE (MM/DD/YY) | LIMITS                        |                 |
|--------|---|---------------|----------------------------------|-----------------------------------|-------------------------------|-----------------|
| 4.     | GENERAL LIABILITY   | (A)           | (B)                              | (C)                               | GENERAL AGGREGATE             | \$(D) 2,000,000 |
|        | <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY                |               |                                  |                                   | PRODUCTS-COMP/OP AGG.         | \$(E) 2,000,000 |
|        | <input type="checkbox"/> CLAIMS MADE <input checked="" type="checkbox"/> OCCUR. |               |                                  |                                   | PERSONAL & ADV. INJURY        | \$(F) 1,000,000 |
|        | <input type="checkbox"/> OWNER'S & CONTRACTOR'S PROT.                           |               |                                  |                                   | EACH OCCURRENCE               | \$(G) 1,000,000 |
|        | <input type="checkbox"/> UNDERGROUND EXPLOSION & COLLAPSE                       |               |                                  |                                   | FIRE DAMAGE (Any one fire)    | \$(H) 50,000    |
|        | <input type="checkbox"/> INDEPENDENT CONTRACTOR                                 |               |                                  |                                   | MED. EXPENSE (Any one person) | \$(I) 5,000     |
| 5.     | AUTOMOBILE LIABILITY  | (J)           | (K)                              | (L)                               | COMBINED SINGLE LIMIT         | \$(M) 1,000,000 |
|        | <input checked="" type="checkbox"/> ANY AUTO                                    |               |                                  |                                   | BODILY INJURY (Per person)    | \$              |
|        | <input type="checkbox"/> ALL OWNED AUTOS  |               |                                  |                                   | BODILY INJURY (Per accident)  | \$              |
|        | <input type="checkbox"/> SCHEDULED AUTOS  |               |                                  |                                   | PROPERTY DAMAGE               | \$              |
|        | <input type="checkbox"/> HIRED AUTOS  |               |                                  |                                   |                               |                 |
|        | <input type="checkbox"/> NON-OWNED AUTOS  |               |                                  |                                   |                               |                 |
|        | <input type="checkbox"/> GARAGE LIABILITY                                       |               |                                  |                                   |                               |                 |
|        | EXCESS LIABILITY  |               |                                  |                                   | EACH OCCURRENCE               | \$              |
|        | <input type="checkbox"/> UMBRELLA FORM  |               |                                  |                                   | AGGREGATE                     | \$              |
|        | <input type="checkbox"/> OTHER THAN UMBRELLA FORM                               |               |                                  |                                   |                               |                 |
| 6.     | WORKER'S COMPENSATION AND EMPLOYERS' LIABILITY                                  |               |                                  |                                   | STATUTORY LIMITS              |                 |
|        |   |               |                                  |                                   | EACH ACCIDENT                 | \$              |
|        |   |               |                                  |                                   | DISEASEPOLICY LIMIT           | \$              |
|        |   |               |                                  |                                   | DISEASEEACH EMPLOYEE          | \$              |
|        | OTHER Professional Liability  |               |                                  |                                   | AGGREGATE                     | \$ 1,000,000    |

7. DESCRIPTION OF CONTRACT: NUMBER AND NAME OF CONTRACT

8. CERTIFICATE HOLDER

University Medical Center of Southern Nevada  
1800 West Charleston Boulevard  
Las Vegas, NV 89102

The Certificate Holder is named as an additional insured.

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING COMPANY WILL MAIL 30 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT,

9. APPOINTED AGENT SIGNATURE

INSURER LICENSE NUMBER \_\_\_\_\_  
ISSUED BY STATE OF \_\_\_\_\_



AFFIDAVIT  
(for sole proprietors only)

C-4

## INSTRUCTIONS FOR COMPLETING THE DISCLOSURE OF OWNERSHIP/PRINCIPALS FORM

### **Purpose of the Form**

The purpose of the Disclosure of Ownership/Principals Form is to gather ownership information pertaining to the business entity for use by the Board of County Commissioners ("BCC") in determining whether members of the BCC should exclude themselves from voting on agenda items where they have, or may be perceived as having a conflict of interest, and to determine compliance with Nevada Revised Statute 281A.430, contracts in which a public officer or employee has interest is prohibited.

### **General Instructions**

Completion and submission of this Form is a condition of approval or renewal of a contract or lease and/or release of monetary funding between the disclosing entity and the appropriate Clark County government entity. Failure to submit the requested information may result in a refusal by the BCC to enter into an agreement/contract and/or release monetary funding to such disclosing entity.

### **Detailed Instructions**

All sections of the Disclosure of Ownership form must be completed. If not applicable, write in N/A.

**Business Entity Type** – Indicate if the entity is an Individual, Partnership, Limited Liability Company, Corporation, Trust, Non-profit Organization, or Other. When selecting 'Other', provide a description of the legal entity.

**Non-Profit Organization (NPO)** – Any non-profit corporation, group, association, or corporation duly filed and registered as required by state law.

**Business Designation Group** – Indicate if the entity is a Minority Owned Business Enterprise (MBE), Women-Owned Business Enterprise (WBE), Small Business Enterprise (SBE), or Physically-Challenged Business Enterprise (PBE). This is needed in order to provide utilization statistics to the Legislative Council Bureau, and will be used only for such purpose.

**Minority Owned Business Enterprise (MBE):**

An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more minority persons of Black American, Hispanic American, Asian-Pacific American or Native American ethnicity.

**Women Owned Business Enterprise (WBE):**

An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more women.

**Physically-Challenged Business Enterprise (PBE):**

An independent and continuing business for profit which performs a commercially useful function and is at least 51% owned and controlled by one or more disabled individuals pursuant to the federal Americans with Disabilities Act.

**Small Business Enterprise (SBE):**

An independent and continuing business for profit which performs a commercially useful function, is not owned and controlled by individuals designated as minority, women, or physically-challenged, and where gross annual sales does not exceed \$2,000,000.

**Business Name (include d.b.a., if applicable)** – Enter the legal name of the business entity and enter the "Doing Business As" (d.b.a.) name, if applicable.

**Corporate/Business Address, Business Telephone, Business Fax, and Email** – Enter the street address, telephone and fax numbers, and email of the named business entity.

**Local Business Address, Local Business Telephone, Local Business Fax, and Email** – If business entity is out-of-state, but operates the business from a location in Nevada, enter the Nevada street address, telephone and fax numbers, point of contact and email of the local office. Please note that the local address must be an address from which the business is operating from that location. Please do not include a P.O. Box number, unless required by the U.S. Postal Service, or a business license hanging address.

**Number of Clark County Nevada Residents employed by this firm.**

**List of Owners/Officers** – Include the full name, title and percentage of ownership of each person who has ownership or financial interest in the business entity. If the business is a publicly-traded corporation or non-profit organization, list all Corporate Officers and Directors only.

**For All Contracts – (Not required for publicly-traded corporations)**

- 1) Indicate if any individual members, partners, owners or principals involved in the business entity are a Clark County full-time employee(s), or appointed/elected official(s). If yes, the following paragraph applies.

In accordance with NRS 281A.430.1, a public officer or employee shall not bid on or enter into a contract between a government agency and any private business in which he has a significant financial interest, except as provided for in subsections 2, 3, and 4.

- 2) Indicate if any individual members, partners, owners or principals involved in the business entity have a second degree of consanguinity or affinity relation to a Clark County full-time employee(s), or appointed/elected official(s) (reference form on Page 2 for definition). If **YES**, complete the Disclosure of Relationship Form. Clark County is comprised of the following government entities: Clark County, University Medical Center of Southern Nevada, Department of Aviation (McCarran Airport), and Clark County Water Reclamation District. Note: The Department of Aviation includes all of the General Aviation Airports (Henderson, North Las Vegas, and Jean).

A professional service is defined as a business entity that offers business/financial consulting, legal, physician, architect, engineer or other professional services.

**Signature and Print Name** – Requires signature of an authorized representative and the date signed.

**Disclosure of Relationship Form** – If any individual members, partners, owners or principals of the business entity is presently a Clark County employee, public officer or official, or has a second degree of consanguinity or affinity relationship to a Clark County employee, public officer or official, this section must be completed in its entirety.

## DISCLOSURE OF OWNERSHIP/PRINCIPALS

|  |                                      |  |   |                                |  |
|--|--------------------------------------|--|---|--------------------------------|--|
| <b>Business Entity Type</b>                              |                                      |  |   |                                |  |
| <input type="checkbox"/> Sole Proprietorship             | <input type="checkbox"/> Partnership | <input type="checkbox"/> Limited Liability Company | <input type="checkbox"/> Corporation      | <input type="checkbox"/> Trust | <input type="checkbox"/> Non-Profit Organization |
| <input type="checkbox"/> Other                           |                                      |  |   |                                |  |
| <b>Business Designation Group</b>                        |                                      |  |   |                                |  |
| <input type="checkbox"/> MBE                             | <input type="checkbox"/> WBE         | <input type="checkbox"/> SBE                       | <input type="checkbox"/> PBE              | <input type="checkbox"/> LBE   | <input type="checkbox"/> NBE                     |
| Minority Business Enterprise                             | Women-Owned Business Enterprise      | Small Business Enterprise                          | Physically Challenged Business Enterprise | Large Business Enterprise      | Nevada Business Enterprise                       |
| <b>Corporate/Business Entity Name:</b>                   |                                      |  |   |                                |  |
| <b>(Include d.b.a., if applicable)</b>                   |                                      |  |   |                                |  |
| <b>Street Address:</b>                                   |                                      |  | <b>Website:</b>                           |                                |  |
| <b>City, State and Zip Code:</b>                         |                                      |  | <b>POC Name and Email:</b>                |                                |  |
| <b>Telephone No:</b>                                     |                                      |  | <b>Fax No:</b>                            |                                |  |
| <b>Local Street Address:</b>                             |                                      |  | <b>Website:</b>                           |                                |  |
| <b>City, State and Zip Code:</b>                         |                                      |  | <b>Local Fax No:</b>                      |                                |  |
| <b>Local Telephone No:</b>                               |                                      |  | <b>Local POC Name Email:</b>              |                                |  |
| <b>Number of Clark County Nevada Residents Employed:</b> |                                      |  |   |                                |  |

**All entities**, with the exception of publicly-traded and non-profit organizations, must list the names of individuals holding more than five percent (5%) ownership or financial interest in the business entity appearing before the Board.

**Publicly-traded entities and non-profit organizations shall list all Corporate Officers and Directors** in lieu of disclosing the names of individuals with ownership or financial interest. The disclosure requirement, as applied to land-use applications, extends to the applicant and the landowner(s).

**Entities** include all business associations organized under or governed by Title 7 of the Nevada Revised Statutes, including but not limited to private corporations, close corporations, foreign corporations, limited liability companies, partnerships, limited partnerships, and professional corporations.

| Full Name | Title | % Owned<br>(Not required for<br>Publicly Traded<br>Corporations/Non-profit<br>organizations) |
|-----------|-------|--|
| <hr/>     | <hr/> | <hr/>  |
| <hr/>     | <hr/> | <hr/>  |
| <hr/>     | <hr/> | <hr/>  |

***This section is not required for publicly-traded corporations.***

- Are any individual members, partners, owners or principals, involved in the business entity, a Clark County, University Medical Center, Department of Aviation, or Clark County Water Reclamation District full-time employee(s), or appointed/elected official(s)?  
☐ Yes      ☐ No      (If yes, please note that County employee(s), or appointed/elected official(s) may not perform any work on professional service contracts, or other contracts, which are not subject to competitive bid.)
- Do any individual members, partners, owners or principals have a spouse, registered domestic partner, child, parent, in-law or brother/sister, half-brother/half-sister, grandchild, grandparent, related to a Clark County, University Medical Center, Department of Aviation, or Clark County Water Reclamation District full-time employee(s), or appointed/elected official(s)?  
☐ Yes      ☐ No      (If yes, please complete the Disclosure of Relationship form on Page 2. If no, please print N/A on Page 2.)

I certify under penalty of perjury, that all of the information provided herein is current, complete, and accurate. I also understand that the Board will not take action on land-use approvals, contract approvals, land sales, leases or exchanges without the completed disclosure form.

|                 |                  |
|-----------------|------------------|
| <hr/> Signature | <hr/> Print Name |
| <hr/> Title     | <hr/> Date       |

## DISCLOSURE OF RELATIONSHIP

List any disclosures below:  
(Mark N/A, if not applicable.)

| NAME OF BUSINESS OWNER/PRINCIPAL | NAME OF COUNTY* EMPLOYEE/OFFICIAL AND JOB TITLE | RELATIONSHIP TO COUNTY* EMPLOYEE/OFFICIAL | COUNTY* EMPLOYEE'S/OFFICIAL'S DEPARTMENT |
|----------------------------------|---|---|--|
|                                  |   |   |  |
|                                  |   |   |  |
|                                  |   |   |  |
|                                  |   |   |  |
|                                  |   |   |  |
|                                  |   |   |  |
|                                  |   |   |  |
|                                  |   |   |  |
|                                  |   |   |  |

\* County employee means Clark County, University Medical Center, Department of Aviation, or Clark County Water Reclamation District.

"Consanguinity" is a relationship by blood. "Affinity" is a relationship by marriage.

"To the second degree of consanguinity" applies to the candidate's first and second degree of blood relatives as follows:

- Spouse – Registered Domestic Partners – Children – Parents – In-laws (first degree)
- Brothers/Sisters – Half-Brothers/Half-Sisters – Grandchildren – Grandparents – In-laws (second degree)

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***For County Use Only:***

If any Disclosure of Relationship is noted above, please complete the following:

☐ Yes ☐ No Is the County employee(s) noted above involved in the contracting/selection process for this particular agenda item?

☐ Yes ☐ No Is the County employee(s) noted above involved in anyway with the business in performance of the contract?

Notes/Comments:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name  
Authorized Department Representative

**INSTRUCTIONS FOR COMPLETING THE  
DISCLOSURE OF RELATIONSHIP  
(Physician Services Contracts)**

**Purpose of the Form**

The purpose of the Disclosure of Relationship Form is to gather information pertaining to the business entity for use by the Board of Hospital Trustees and Hospital Administration in determining whether a conflict of interest exists prior to awarding a contract.

**General Instructions**

Completion and submission of this Form is a condition of approval or renewal of a contract or lease and/or release of monetary funding between the disclosing entity and UMC. Failure to submit the requested information may result in a refusal by the UMC to enter into an agreement/contract and/or release monetary funding to such disclosing entity.

**Detailed Instructions**

All sections of the Disclosure of Relationship form must be completed. If not applicable, write in N/A.

***Business Name (include d.b.a., if applicable)*** – Enter the legal name of the business entity and enter the “Doing Business As” (d.b.a.) name, if applicable.

***Corporate/Business Address, Business Telephone, Business Fax, and Email*** – Enter the street address, telephone and fax numbers, and email of the named business entity.

***Local Business Address, Local Business Telephone, Local Business Fax, and Email*** – If business entity is out-of-state, but operates the business from a location in Nevada, enter the Nevada street address, telephone and fax numbers, point of contact and email of the local office. Please note that the local address must be an address from which the business is operating from that location. Please do not include a P.O. Box number, unless required by the U.S. Postal Service, or a business license hanging address.

A professional service is defined as a business entity that offers business/financial consulting, legal, physician, architect, engineer or other professional services.

***Signature and Print Name*** – Requires signature of an authorized representative and the date signed.

**Policy**

It is the policy of University Medical Center of Southern Nevada (UMC) Medical Staff that all staff members granted membership and/or privileges including those providing contracted services to the organization shall act in good faith to fulfill their responsibilities. In order to achieve this goal, all staff members and practitioners shall voluntarily fully and openly disclose any actual or potential conflict of interest at the time they arise in the course of providing or directing patient care, conducting the affairs of the organization, or providing services to the organization.

**Definition**

An actual or potential conflict of interest is present when an actual or potential conflict exists between an individual’s duty to act in the best interests of UMC and the patients we serve and his or her desire to act in a way that will benefit only him or herself or another third party. Although it is impossible to list every circumstance giving rise to a conflict of interest, the following will serve as a guide to the types of activities that might cause conflict of interest and to which this policy applies.

**Key Definitions**

**“Material financial interest”** means

- An employment, consulting, royalty, licensing, equipment or space lease, services arrangement or other financial relationship
- An ownership interest
- An interest that contributes more than 5% to a member’s annual income or the annual income of a family member
- A position as a director, trustee, managing partner, officer or key employee, whether paid or unpaid

**“Family member”** means a spouse or domestic partner, children and their spouses, grandchildren and their spouses, parents and their spouses, grandparents and their spouses, brothers and sisters and their spouses, nieces and nephews and their spouses, parents-in-law and their spouses. Children include natural and adopted children. Spouses include domestic partners.

**“Ownership”** includes ownership through sole proprietorships, stock, stock options, partnership or limited partnership shares, and limited liability company memberships.

**“Personal interests”** mean those interests that arise out of a member’s personal activities or the activities of a family member.

## DISCLOSURE OF RELATIONSHIP (Physician Service Contracts)

|  |  |
|--|--|
| <b>Corporate/Business Entity Name:</b> |  |
| <b>(Include d.b.a., if applicable)</b> |  |
| <b>Street Address:</b>                 |  |
| <b>City, State and Zip Code:</b>       |  |
| <b>Telephone No:</b>                   |  |
| <b>Point of Contact Name:</b>          |  |
| <b>Email:</b>                          |  |

3. **OWNERSHIP** - Do you (or does a family member) have an ownership interest in any company that provides goods or services to the Hospital, or otherwise does business with the Hospital?

☐ Yes ☐ No (If yes, complete following.)

| Name of Person<br>(self or family member) | Name of Company | Percent of Ownership | Type of Services Provided by the Company |
|---|-----------------|----------------------|--|
| 1.  |                 |                      |  |
| 2.  |                 |                      |  |
| 3.  |                 |                      |  |

*(Use additional sheets as necessary)*

1. **COMPENSATION ARRANGEMENTS** - Do you (or does a family member) have an employment, consulting or other financial arrangement (including, without limitation, an office or space lease, royalty or licensing agreement, or sponsored research agreement) with a company that provides goods and services to the Hospital or otherwise does business with the Hospital?

☐ Yes ☐ No (If yes, complete following.)

| Name of Person<br>(self or family member) | Name of Company | Describe the Compensation Arrangement | Dollar Value of Compensation |
|---|-----------------|---------------------------------------|------------------------------|
| 1.  |                 |                                       |                              |
| 2.  |                 |                                       |                              |
| 3.  |                 |                                       |                              |

*(Use additional sheets as necessary)*

2. **BUSINESS POSITIONS** - Are you (or is a family member) an officer, director, trustee, managing partner, officer or key employee of a company that provides goods and services to the Hospital or otherwise does business with the Hospital?

☐ Yes ☐ No (If yes, complete following.)

| Name of Person<br>(self or family member) | Name of Company | Business Position or Title | Dollar Value of Compensation<br>(include meeting stipends and travel reimbursement) |
|---|-----------------|----------------------------|---|
| 1.  |                 |                            |   |
| 2.  |                 |                            |   |
| 3.  |                 |                            |   |

*(Use additional sheets as necessary)*

I certify under penalty of perjury, that all of the information provided herein is current, complete, and accurate.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date